MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Horizon Ballroom
Ronald Reagan International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, November 7, 2002
10:28 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

***November 8th proceedings begin on page 247**

AGENDA PAGE

NOTE: November 8th proceedings begin on page 247

P R O C E E D I N G S

MR. HACKBARTH: I apologize to our guests for the late start this morning. Our first topic today is Medicare in the context of the federal budget.

For those of you who haven't attended recent meetings, this is one of a series of presentations we've had on Medicare rates of increase in spending, Medicare relative to private spending on health care. The purpose of this is to lay the groundwork for consideration of our recommendations in the broader context of the federal budget. This is something new that the Commission is undertaking for this cycle and you'll hear more about it later. As I say, this is all background material at this point. Scott and Ann.

DR. HARRISON: Good morning. As Glenn just said, this is part of our continuing efforts to give you background for making recommendations and we're presenting some information today on the fiscal context surrounding the Medicare program. Previously we gave you information on Medicare-specific spending and comparisons to other payers. For the December meeting we will present information on spending by beneficiaries. And in future years we expect to

compact these presentations perhaps into one session.

Today we will look briefly at three different sets of fiscal circumstances involving the Medicare program. First we will look at the federal budget. Medicare policy often becomes intertwined with budget policy because Medicare is such a significant portion of the total federal budget. Also, because the Congress must usually consider budgetary ramifications when it makes Medicare policy decisions, our budget recommendations are often viewed by Congress through a budgetary perspective.

In addition to the budget, the status of the trust funds that are used to finance the Medicare program can also exert pressure on Medicare spending, and we'll look at those. And finally today, we'll look at the total resources of the American economy that is, after all, the basis of financial support for the Medicare program.

Medicare is an increasingly significant portion of the federal budget. Throughout the '80s, Medicare program outlays accounted for between 6 and 8 percent of total federal spending. Over the course of the '90s, Medicare's share increased sharply to 13 percent by 1997, dipped a little bit after BBA, and then returned to 13 percent.

According to the Congressional Budget Office Medicare is projected to remain about 13 percent of federal spending until about 2007, when it begins to grow faster than overall spending, reaching 16 percent of total spending by the close of the budget window in 2012.

Let me just say a few words about projections here. There are many different projections of the federal budget and of Medicare spending. For projections over the next 10 years we have tended to rely on CBO estimates because CBO is the official budget estimator for Congress and they put a lot of time and effort into projections for the next ten years. Its projections assume that current law does not change over the projection period.

The Medicare trustees also put great effort into estimating Medicare spending and they project out 75 years. Because their projections of Medicare spending are based on many factors including current law, and projections of economic growth, general economic inflation, medical technological change, fertility, immigration and life expectancy, these things cannot be predicted with certainty so the trustees make three sets of projections: low-cost, high cost, and intermediate which they also call their best

estimate.

As it happens, the projections from the intermediate model and CBO projections are very similar over the next ten years but you can see that the high and low give quite a spread.

This slide shows the recent trend in Medicare spending and the range of spending projections over the next ten years. From 1987 to 1997, Medicare program spending steadily increased from approximately $80 billion up to $200 billion. Spending slowed greatly in the late '902 due to BBA provisions and increased fraud and abuse scrutiny, but increased to $238 billion by 2001.

CBO and their trustees, using the intermediate model, project a 26 percent increase to approximately $300 billion by 2006 and a doubling to approximately $475 billion by 2012.

Real growth in Medicare spending is projected to average about 4 percent per year under these models. Under the trustees' low assumptions real growth would be in the 1 to 2 percent range. And under the high cost model it would be about 6 percent.

Naturally policymakers are more likely to focus on

budget ramifications when the budget is in deficit, so let's quickly look at the surplus and deficit projections. The federal budget surplus or deficit status is calculated and projected using two different methods, the on-budget and the total measure.

The total budget figure includes the Social Security trust funds as well as the net cash flow from the Postal Service while the on-budget figure exclude these items. Currently the total budget looks more favorable than the on-budget figures because the Social Security accounts are currently running a surplus.

From the 50's to '98 or '99, depending on which measure you use, we ran deficits. Depending on which measures used, the budget can be said to have surpluses during the '98 to 2001 period, in the range of $70 to about $238 billion. We ran a deficit this year under both measures, $159 billion for the total budget and $314 billion if limited to on-budget items. The total budget is projected to be in surplus again in 2006 but on-budget a surplus is not expected again until 2011. These numbers are based on CBO projections and are based on current law.

The sharp upturn in the surplus in 2010 is due to

the fact that current law presumes that the most recent round of tax cuts will actually expire at that point. That's the way current law works.

Now let's talk about the Medicare trust funds. The Medicare program is financed through two trust funds, the Hospital Insurance, or the HI trust fund, and the Supplementary Medical Insurance, or SMI trust fund.

These funds are financial accounts in the U.S. Treasury that receive income from the sources I'll describe and issue payments for Medicare benefits and program administration including MedPAC. The HI fund pays benefits for Part A services while the SMI fund is used to pay for Part B services. The funds cannot be commingled. In other words, the HI fund cannot be used to pay for part B services and the SMI fund cannot be used to pay for Part A services.

The HI and SMI accounts are financed very differently. The HR funds receipts come primarily from payroll taxes which accounted for 47 percent of the revenue in 2001 and interest earnings on the fund balances which accounted for about 8 percent. The remainder is from premiums from those few beneficiaries who buy into Part A, taxes on Social Security benefits, and some other assorted

sources.

In contrast, SMI's receipts come primarily from the federal general revenues and secondarily from beneficiary premiums. Part B premiums are set by law. In BBA they were set for the last time at 25 percent of each year's projected cost for aged enrollees. General revenues provide the bulk of the remaining funding. Since Part B spending generally increases from year to year, premiums increase each year in proportion. For instance this year premiums are $54 a month and next year they will be $58.70 a month.

Looking at the trust fund financing helps to illustrate how different stakeholders would be affected by different types of Medicare policy decisions. Changes that affect Part A costs would affect the health of the HI fund and could put pressure on reducing costs or changing the 2.9 percent payroll tax on worker wages that finance the HI fund. Changes in Part B spending would affect taxpayers in general and beneficiaries whose premiums change automatically to finance 25 percent of any changes.

From a budgetary perspective changes to Part B result in relatively smaller changes to the overall federal

budget because 25 percent of the change would be offset by premium changes. We saw a little bit of shifting in BBA were a lot of home health spending was moved from A to B which pushed out the solvency of A but which increased premiums in B.

As we worry about budget deficits, we also worry about the solvency of the trust funds. The trustees reassess solvency dates annually. Economic and legislative changes can quickly alter projections of solvency in much the same way as they alter annual budget surplus and deficit projections.

The HI fund is projected to become insolvent in 2030 under the trustees' intermediate estimate, as is shown on this slide. On this slide, this is using the intermediate projections and this is the fund balance as a percent of expected expenditures for the next year. So right now we're at a little over 100 percent, which means if we didn't take in anything this year, we could still pay for one years worth of spending.

You can see, in 2016 costs are projected to begin exceeding tax revenues, requiring the fund to use interest income to pay some costs. At this point, the Part A program

also becomes a net cost to the federal budget. Right now it's actually running a surplus and helps the budget.

In 2021, projected costs would exceed all HI income, necessitating the spending down of trust fund assets to meet costs. And then finally, in 2030 the HI fund assets are projected to be exhausted. Under the trustees' low estimate, the HI fund would remain solvent throughout the 75-year projection period that ends in 2076. Under the high-cost estimate, however, it would be exhausted in the year 2018 and costs would exceed revenue by 2008.

In contrast to the HI fund, the SMI fund is designed to remain solvent indefinitely. Current law automatically sets annual financing to cover SMI's expected costs for the upcoming year plus a contingency reserve. However, as the beneficiary population grows due to the retirement of the baby boom generation and as health care costs continue to rise, the SMI fund is expected to require increasing amounts of general revenue and substantial increases in beneficiary premiums.

Which brings us to the economy. The economy is an integral component of any discussion of trust fund solvency and sustainability of federal and/or Medicare spending.

Economic projection, as measured by GDP, is the basis of all tax revenues that finance government spending. In the coming years the economy is projected to bear an increasing burden in supporting Medicare spending. Medicare is increasing as a percent of GDP. For the historical period from 1980 to 2001 its share rose from 1.2 percent at the beginning to a high of 2.8 percent in 1997, and again as a result of BBA and strong economic growth, Medicare spending declined slightly as a share of GDP to 2.2 percent in 2000. However its since risen back up to around 2.5 percent and it's projected to increase steadily to 2.8 percent by 2012.

The economy will be challenged further after that as the baby boom generation continues to age and the elderly make up a larger share of our population. And by 2030 Medicare is projected to rise to 4.5 percent of GDP.

MR. HACKBARTH: Comments.

DR. REISCHAUER: I guess I'm not quite sure what we're going to do with this in the long run, but the thing that concerns me most, Scott, is that we're accepting the CBO baseline as if it were an achievable or realistic view of the future. While historically that's been more or less the case there's really never been a period in which the

likely future diverges as significantly from what this baseline has in it as assumptions.

And so we're sort of, I think, perpetuating misinformation here with these projections and the percentages. But how you get out of that situation I'm not sure because there is no -- are you going to give us the Wellpoint baseline?

MS. ROSENBLATT: No, I was going to say the technical panel, which I believe is a public document, right? I was going to suggest that maybe -- there was a technical panel in late 2000, 2001 that had three or four actuaries on it, I was one, and a couple of economists on it. I think if we took some good quotes from there we might help --

DR. REISCHAUER: You're talking about the Medicare numbers. What I'm talking about is the size of the budget numbers. And we have a Cinderella's coach tax plan out there that's going to disappear and a number of other absolutely unsustainable components in the baseline that make the budget look a lot smaller and the deficits turn to surpluses. And if anyone wants to give me a bet on that one I'll take it. At a minimum we have to describe in more

detail what the limitations are of that analysis. I'm not being much help to you.

DR. HARRISON: I just wonder how deeply we want to get into talking about non-Medicare projections. I don't know.

DR. MILLER: But I think describing the limitations on this information [inaudible] and one of the reasons that we expressed it as a percentage of GDP, which also has altered the forecast, is to also take it out of the context of the budget and say that there are different ways to look at it. Either way you look at it it's still pretty aggressive growth over the long haul.

DR. REISCHAUER: Another dimension you might want to look at is as a percent of projected national health expenditures.

MR. MULLER: In the context of the budget and for the reasons that Bob suggested and others, looking out 10 or 15 years is difficult in any kind of scenario. But is the expectation that we look at more in a shorter time frame or obviously as one looks at 10, 15 or 20 years it's so speculative. So in the context of the federal budget, just looking at the title slide here, is the expectation that

we're looking at one, two, three years or is it more that we're looking at this multi-year horizon?

MR. HACKBARTH: The purpose of this, as I see it, is not to in any way connect it, hardwire to our recommendations. Obviously the long-term situation of the Medicare program is way beyond the ability of this Commission to resolve. There are factors that go way beyond Medicare payment policy involved in creating those numbers. It is simply context for discussion. The more immediate concern for us and for the people on the Hill that we serve is the short-term fiscal picture and the fact that we've now again returned to deficit spending. It certainly influences or seems to be influencing the people that I've talked to and how they look at the Medicare decisions they must take.

So that, for me, is the most immediate, most relevant portion of these presentations. But here again, what does that mean for our recommendations? There is no clear answer to that. I think we need to be cognizant of the resource constraints that exist but of course there are consideration on the other side as well, in terms of ensuring beneficiaries access to quality of care.

So there is no one-to-one correspondence between

the deficit figure Medicare payment policy recommendations. It's just background.

MR. MULLER: As the slides indicate, the trust fund is in reasonable surplus, what until 2012 or so, right? No?

MS. ROSENBLATT: No, if you read the technical report I was talking about, it would say the intermediate is not totally an intermediate.

MS. BURKE: Two points. One following up on the side comment by Bob. I think there are a couple of reasons to do this. One is this sort of set Medicare in the context of the broader budget and give a perspective on how big a player it is and why it is so influential in terms of how we make decisions.

But also, it's to set it in the context of health program and the national health expenditures and giving some context for Medicare as a player in that may also make some sense in terms of explaining where Medicare is. So adding that, rather than substituting it, but adding that, so you have a concept that Medicare is the big gun. Everything we do essentially has an enormous impact on the system as a whole. So I think that might be useful.

The other thing I would suggest is while this reflects what we perceive to be current law and all of that has be considered in that context, there may be value in at least noting specifically when we say that it reflects current law that it does not -- I mean it doesn't, in part of the text, talk about the number of things that have to be taken into consideration going forward, demographics, changing technology, and so forth. But the very specific indicating that it does not currently cover drugs. Because of that impact in terms of it, as a statement of what the actual costs are, I think might be useful as well. So a particular note that these projections, which are assumed through current law, don't for example include the coverage on pharmaceuticals, outpatient pharmaceuticals, I think might be an important point to make as well, not a recommendation, but rather just setting the context.

MR. FEEZOR: I just wanted to second what I think both Bob and Sheila talked about, about having some other context other than budget, and that would be either national health expenditures, maybe even a percentage of total health care of this population that actually is covered during this time, particularly pulling up the issue about drugs as we

shift, in terms of how our treatments are.

And then I just would have a question, I'm curious. Mark, do you know how the federal government plans to deal with the forthcoming GASB issue on retiree health care costs specifically in terms of the at the FEHBP program?

DR. MILLER: I don't know that. I can look into it and come back to you, but I don't. You're right, that decision did -- there was a --

MR. FEEZOR: It's coming up in June, I think will be the issue on the reg on that. It would be interesting in terms of what it does to the budget or not.

DR. MILLER: I'll run it down.

MR. SMITH: I'll be very brief. Alice and Allen made the main points I wanted to make. But let me come back to Bob's point. There's probably never been a time, certainly since most of us have been around this discussion, when the CBO projections diverged as much from reality as these do, rather than go into a discussion about what's going to happen to the ATM or what's going to happen to the expiring tax provisions in 2010, it would be better to say less about the budget context and more about the health

expenditure context. I don't think we can entirely take it out of the budget but it simply isn't very useful. And to the extent what we keep saying it and looking at it, it reinforces a set of illusions.

Whereas the health shares and the share of Medicare as a share of all beneficiary costs and Medicare as a share of all health costs, those are reasonably good numbers and do tell us something which is worth keeping in mind.

DR. NEWHOUSE: I like the health expenditure suggestions and I was going to also suggest that in a numerator we do a calculation beneficiary plus federal spending to show that -- and this somewhat handles the drug benefit since what doesn't go in one place tends to go in the other. One could, of course, include the employer spending retiree health benefits there as well.

And then I thought one could also make it too elaborate a chart, but one could do it with and without long-term care since long-term care both affects the beneficiaries and the federal budget through Medicaid.

So in other words, this would get at more the issue of costs for the over-65 and how that burden is being

divided between the taxpayers and the elderly.

MR. DURENBERGER: Mr. Chairman, like those who have spoken before on this subject, my question relates largely or my suggestion will relate largely to the value of this information as it appears in the March report.

As I read through that the briefing materials, one of the observations -- one of the notes I made to myself was it might be valuable to express in there the experiences that Sheila and I and others had by the mid-80s in trying to make health and Medicare policy on the budget resolution, which is sort of a challenge that is still being presented to people. So it's always been people like Bob and his predecessors and successes at CBO who have strongly influenced the decisions that were taken by people in the Senate and the House. But it's complicated by the fact that rarely do any of these people do Medicare policy separate from the budget resolution.

I think some expression of that as a contextual challenge to policymakers is helpful. But in that regard my comment goes somewhat beyond that.

What is really important I think to those decisionmakers, again over time, not in the near-term

context. I think this is fine in the near-term context. But in the longer-term context for those that would like to change the program in particular and for those that would like to recommend changes that might cost a little money in the short term in order to affect is the whole issue of cost drivers and the necessity to begin to deal with the realities of what are the cost drivers. This get to the health expenditures and that sort of thing. What are the real cost drivers in the system? And what can we project will be the impact on costs by increasing the physician payment versus something else in the system or altering the way in which we pay for decisionmakers like physicians versus people like hospitals or other whatever the case may be.

That seems to be the challenge presented today to offset all of the influence that spends much more time on the Hill than we do to try to say this is good policy or bad policy. You have to say let's put what you're recommending to me as one of these interest groups in the context of the role that your advice to me will play in cutting into or increasing the deficit in the future, whatever the case may be.

So I just think that -- and I don't know whether it's relative to just presenting budget facts or not. I'm saying from an experiential standpoint, getting at the whole issue of what's the realities of the cost drivers in the system and how each of these budget decisions or budget-related decisions affects that particular cost driver in the system is something that's worth spending a little time at. It may not be in the context.

MR. HACKBARTH: Could you just elaborate, Dave, a little bit on what you mean by cost driver and give some examples?

MR. DURENBERGER: Joe is the best person probably to give the examples because we see his lists periodically , but my experience, not so much then as now because I may not have understood it as well until I got outside of the context of having to make decisions. Now I only talk about it. That the whole issue of what drives the cost side of the health care delivery system is much misunderstood because everyone who has an interest in preserving the current system blames somebody else for causing the problems.

So we can start with aging, we can go to

technology. We can keep going on and on and on and on. Rarely do we ever get to the real cost drivers within the system.

So my point is it's hard for the reformer who's coming with a specific recommendation to change some part of the system, the way in which we reimburse certain physicians for certain kinds of procedures, to demonstrate that over time this will lessen the impact both on technology costs and on average length of stay in a hospital or whenever the case may be. So I'm just saying in the context that all of this has been presented to us, you guys never take into consideration the budget consequences. I'm saying one of the things I think that some of these people are really getting at it is are we appropriately considering this idea of how decisions taken by the Medicare program or by the people who are paid through the Medicare program are going to influence costs this way or this way without affecting quality or outcomes or whenever the case may be.

Now try to say that better, please?

MR. HACKBARTH: Let me just pick up on the point and Joe and Bob and others can correct me when I'm wrong, I'm sure I'll say several things that are wrong. But if you

think in terms of the drivers -- I haven't said anything yet, I can't be wrong yet -- there are the obvious, the growth in the number of beneficiaries, aging, my understanding of the research is those are things that over long periods of time can have an effect but on relatively short horizons they are not major drivers. Price increases, the amount we pay per unit of service is another factor.

But the really big ones are the advantage of new technology and then the expanded use of technology, the diffusion of technology, and patterns of care. A obviously those two are intertwined but the very significant difference in patterns of care across the country is another factor of interest to me.

To me the significance of your point is that most of our current policy levers are focused on price and we're trying to use the price lever to control the Medicare budget and future growth and it's a tool ill-suited to that very large task. If we're really serious about affecting the growth in Medicare spending or the growth in health care spending in general, we've got to get beyond just using a price lever.

To me that would be the important -- one of the

important policy implications that come out of this contextual discussion.

MR. DURENBERGER: You said it better than I and when we listened to Don Berwick last time present on quality, and Brent as well, they talked about one of the impediments to the business -- the business case was we continue to pay for defects. But a lot of people looking at that would have no idea what we're talking about, but it gets to the issues of evidence-based medicine and what do we actually pay for in the system and those kinds of things, which I'm saying in the longer run are a lot more important to policymakers who are thinking about these issues, both short and long term than just the kind of data that we see here.

This data is set in the context of competition. Here's the nursing homes versus the home health versus the hospitals versus the docs competing over this when we've got 20 years of history with this now, competing over this pie. And each one has to get their share of their pie. And up on the Hill people get increasing frustrated because they aren't seeing any change in the line of growth which is what they really would like to see.

DR. NEWHOUSE: It's actually that last remark that I would build off of. It's important to distinguish why costs are high as opposed to why costs are rising and the point about variations or about waste or about administrative costs probably has much more to do with why costs are high than why costs are rising.

For example, I haven't looked at the data but I wouldn't be surprised that costs are rising about as fast in Minneapolis and Portland as they are in Miami but obviously the level of cost is very different.

Then I wasn't sure, Glenn, what you meant by a price lever because price in the broadest sense, if it's defined to include how large is the bundle, is the policy. What you include, what you pay, and then also coverage decisions which also you can kind of conceptually think of that as price increase. If you don't cover it, you don't pay for it

I'm not sure what else there is, that is short of trying to second guess every medical decision which we're not going to do.

DR. REISCHAUER: And is illegal.

DR. NEWHOUSE: And is illegal, yes.

So I wasn't sure what you had in mind with the comment about price as a lever.

MR. HACKBARTH: You're right, if you expand the bundle large enough then you're dealing not only with the price but also the volume of service. You've change the incentive. But the point I'm making is that under our current payment policy I don't think that we really do address many of the important issues of volume of service. That's what I mean by the patterns of care.

Incidentally, I do agree with your point that most of those go to spending high as opposed to the rate of increase in the future but if you really want to control Medicare spending you've got to, I think, deal not just with the price but the volume and the current payment policy tools, I don't think, really adequately address volume of care and patterns of care.

DR. NEWHOUSE: I would say the sustainable growth policy was an effort to address that point and I don't think we're too happy with how it's been working.

MR. HACKBARTH: But one of my chief complaints about it is it does zero about the volume of care. If anything it creates incentive for greater volume. It is

strictly a spending control. It has nothing to do with altering patterns of care. It is entirely wrongheaded in that regard.

DR. REISCHAUER: Other than that, how did you like the play, Mrs. Lincoln.

[Laughter.]

DR. REISCHAUER: This is all very interesting, it strikes me, but we're really digressing from what the purpose of this was, which was to set out the context for our March report. The real question, I think, that is before Mark and Scott and Ann is how broad should that be? We're into this, in large measure, because we were criticized for appearing to be insensitive to the budget constraints that Congress faced and rightly this focused on that and then we jumped all over Scott and began to expand it.

I think this really should be kept to a very short description of how big a gorilla is Medicare, viewed relative to the economy, viewed relative to the budget, viewed relative to national health expenditures? And that that can be done in a very succinct and short way and any attempt to elaborate -- and I know I've been here talking

about elaborations -- is going to create a little more confusion. And these other things that we've been talking about really belong in more detailed analytical treatments later on.

MR. MULLER: I agree with that. Also, since we did some very interesting work last spring on Medicare in the context of total health expenditures for health, and I'd like to see more legs on that work. Sometimes when you do something one time and you don't come back to it, then people forget about it. So I think the comments that were made earlier about looking at Medicare as a share of total health and whether it's putting in private drugs or long-term care and so forth, I think it's important for us to continue to be putting out there, especially in light of all the good work we did last spring. So I would like to see that.

I think in terms of policy, as people think in two, three, four, five year terms, if in fact there are dramatic shifts in the share that Medicare is of total health expenditures for the population, and even interesting contrast between what the over-65 pay versus what the 21-to-64s pay, and so forth, might be useful information for us to

keep putting forth. So I think that information on what Medicare is of health expenditures, which is one of the three listings that Bob just made, is one that I would especially urge us to keep focusing on, especially in light of the discussion about a half hour ago about how difficult it is to deal with some of these budgetary projections.

MS. MARSHALL: Dan and Scott and I have just been reminding each other that we just looked at Medicare as a percent of national health expenditures in the last presentation last month. Is there any discussion here of relative weight that we want to put on Medicare as a share of total budget or Medicare as a share of expenditures when we start to wrap this all together in the chapter? Is there any preference or distributional issue we want to think about there? Or that you want us to think about?

MR. SMITH: Let me take a crack at it. It seems to me that several folks, Bob and Ralph, said that they would like to see more, both Medicare in the context of health spending and the distribution of Medicare spending for beneficiaries, some of the work that you did before would both be useful.

But I want to try to amplify something that Bob

said. Our payment recommendations, which is what Congress is really concerned about our paying attention to the economic consequences, regardless of what we did these slopes aren't going to change and it is very important to remind ourselves of that, both not to spend too much time on this, as Bob says, but also not to thing that this solves the problem of trying to look at economic impact. Economic impact in the context that we've been asked to look at it, really means budget impact within the current first or second year of the budget cycle not these long term numbers.

So we ought to do both, but the long term numbers ought to be less budget and more health care and the short term look, Mark, I still think we have an issue of how we treat the budget consequences of payment update recommendations which this doesn't really help us with much at all.

MR. DURENBERGER: I'm sorry, I don't want to act like I don't want to let this issue go, but if in fact we just present this kind of information, everybody will say well obviously they're paying attention to the budget. People that like to compare Medicare spending increases with other health expenditure increases will say Medicare is

doing a pretty good job. And those want to say that Medicare is the kind of program that we want to be running all over the country. The private sector and everybody else will say that hey, let's all adopt the Medicare model and I don't believe that's right.

I think the distinction that Joe and Glenn made here about trying to introduce into whatever we do in March or June that expresses the difference between why costs are high and why costs are rising, I think that best sums up the point I've been trying to make because Medicare does contribute to both. Medicare has built a foundation in this country on why costs are high because of the way it reimburses or the things that it doesn't pay for, in some cases.

It is also contributing, maybe to a lesser degree than other systems in the country, to why costs are rising. But that particular distinction that has been made here between those two, to the extent that it is a critique both of the Medicare program and of other third-party payment systems I would argue is a kind of a distinction that we ought to start making if in fact in the future we're going to be recommending payment changes -- or on the nature that

you've suggested what are we actually paying for -- that will be welcome on the Hill even though they may appear to be increasing the near mid-term budget consequences.

MR. HACKBARTH: When do we actually see a draft of this initial chapter? We've seen data the last few months. At some point we've got to turn that into what the data mean. Will we have that for the December meeting?

MS. MARSHALL: Yes, I think we will have it for the December meeting. We'll add on one new portion to it that you haven't seen yet. We're going to do this in four stages, Medicare growth overall, spending by sector to that kind of growth, and we did compare to the national health expenditures and other health spending indicators. We did that last time. This was Medicare in the context of the federal budget. And then we were going to focus on beneficiary, people have mentioned out-of-pocket, how much are we spending on different types of beneficiaries.

And hopefully, we'll give you a draft of all of that, hopefully.

MR. HACKBARTH: So in December we'll have an opportunity to resume this discussion about what are the really salient points that need to come out of this. I

don't think we can constructively spend much more time on it now. So thanks, Scott and Ann.

Let's move on to our next item which is emergency department use and beneficiaries access to care.

DR. NELSON: While they're coming up Glenn, I want to express support for a very focused narrow view of this, as Bob Reischauer outlined, rather than getting into all of the multiple complex factors and whether changing the payment system might do something with the slope of expenditures in the future. To really come back and visit this, right now I...

DR. BERNSTEIN: Good morning. In previous meetings staff have presented some background information on beneficiaries access to care and reviewed our plan for looking more closely at some of the particular aspects of access. One of the issues we're looking at more closely this year is the use of emergency department services.

There are two equally and important aspects of ED use that have to be taken into consideration, the availability of timely high-quality emergency care and the extent to which the use of ED services can serve as an indicator of gaps in access to care.

Today I'm going to focus on the second of those topics. The material I'm going to try to cover as quickly as possible is divided into two basic parts. The first is a review of some basic issues surrounding the use of ED service as an indicator of access problems. And secondly, I'm going to briefly go over some available data on trends and analyses of ED use rates for older Americans using a variety of data sources.

In the field of public health and health services research, the use of emergency department services is associated with gaps in adequate primary care or poor care management including not having a usual source of care. For Medicare beneficiaries changes over time in ED use could indicated changes in beneficiaries' ability to obtain appropriate preventive care or primary care. Changes in the pattern of visits to the ED from post acute settings such as home health or skilled nursing care or rehab could indicate problems in access to appropriate acute care.

Finally variations in the patterns of ED visit among populations could indicate disparities in the availability or barriers to the use of regular stable primary care for some beneficiaries.

This table, which comes from the National Health Interview Survey, suggests that among the adult population living in the community in the United States the emergency department is a rather familiar place. About one-fourth of seniors over the age of 65 living in the community went to the emergency department at least once in 2000. One in ten went to ED two or more times.

Assessing the implications of ED use, however, is not easy. I'm not even sure it's possible. In the audience today is Kathy Burt, who directs the Ambulatory Care Studies Branch at NCHS and who's authored a number of key studies using NCHS data is here. And if there are any difficult issues or questions she can answer them.

For any of you that want this report that she has updated fairly recently that looks at emergency room utilization from 1992 to '99, Kathy can help you get copies of it or I can give you Xerox copies.

The points I want to make here are that the use of EDs is important and necessary particularly for people with serious health care problems. As the population ages use of the ED services might increase for a lot of good reasons.

Data from NCHS includes a measure of the immediacy

of need for care for people going to the EDA and essentially what it shows is that using hospital emergency department triage criteria, most people who go the ED need to be there. Only a small proportion of people over age 65 are categorized as non-urgent when they visit the EDA. That doesn't mean that the care they end up getting has to be provided in an emergency department setting but it does mean that according to triage criteria there's a reason for them to be at the ED.

The demand for emergency services also needs to be considered in the context of the shrinking number of emergency departments across the United States and hospital work force shortages. Emergency department closings and the diversion of cases to other facilities could affect ED use rates. So ED rates might be constrained by lack of access which could limit their utility as indicators.

Changes in the use of ED services by beneficiaries coming from post-acute or from long-term care settings could also be related to factors other than access to appropriate care, including the quality of care that people are receiving. Payment incentives could also affect the way that long-term care or post-acute care facilities tend to

make use of emergency services when problems develop with their residents.

Finally, federal and state laws and the ways in which they're enforced also affect the ways in which EDs operate and therefore could affect use rates.

If that wasn't bad enough we have some data problems. I don't want to get bogged down here and I'm not going to go through the chart, just point out some basic issues.

The National Hospital Ambulatory Medical Care Survey, which I'm not going to ever say again, counts all visits by everyone. This includes people from the community, people living in institutions, homeless people, foreign nationals, et cetera. The survey collects information on visits including patient characteristics and what happened during the visit and it's a very valuable source.

However, the survey is based on visits rather than people and rates can't fully explain the variation in use of ED services. Each visit is an independent observation and visits by particular individuals can't be linked. You can't tell from that survey whether a relatively rate of use for a

particular population is due to everybody having some visits or a subgroup having a very large number of visits. Ten visits by one person counts the same as one visit by ten different people.

Other sources also have limitations. The National Health Interview Survey and the Medical Expenditure Panel Survey don't include people living in institutions which is about 5 percent of beneficiaries. The MCBS has an institutional sample which is very valuable. It's called the facility sample. But the number in it is fairly small. Also there are coding conventions in MCBS that make it very difficult to identify the actual number of visits that beneficiaries had in the ED in a given year.

The more complete MCBS cost and use file uses claims data to verify ED and other outpatient use. For ED services, however, this has caused problems because claims are unreliable for ED visits for a variety of reasons including the 72-hour rule where if a person is admitted within 72-hours to the hospital there is no separate hospital bill for it. It's part of the DRG. And then the bills from physicians seeing patients in emergency departments are incomplete because house staff don't submit

bills. Only independent doctor bills are there.

I could go on for another 15 minutes. These data are really incomplete and that's why I'm not going to be presenting any numbers from the MCBS later in my presentation.

But I do want to focus a little bit more on the NCHS, National Health Interview Survey, and the Hospital Ambulatory Survey that I referred to previously with all the initials.

The key points here are that the use of ED services are going up among older Americans. This is not news. It's in these printed reports and we can get you copies of them. But what I want you to note is that the increase in ED visits appears to be associated with more complex medical problems. The increase in the visit rates for adverse effects of medical treatment suggests that more seniors coming to the ED are likely to be in the process of being treated for serious health care problems. Remember these visits include people coming from post-acute care as well as from the community.

There's also been an increase in drug mentions. And what that means is that more people coming to the ED,

more seniors, are as part of their workup having drugs indicated as relevant to their visit. That could mean they're getting a prescription, they're getting their prescription continued, they're actually being given prescription drugs, et cetera.

What we want to note here is that while drugs are clearly more important over time and you would expect there to be an increase over the course of the '90s, there also could be issues about drug interactions or problems about beneficiaries ability to manage an increasingly complicated drug regiment or possibly some of these visits have to do with the fact that people don't have the drugs that they need.

The next chart goes into an issue that was raised in the NCHS work that they spent a great deal of time trying to understand. I'm going to gloss over this very quickly. It won't seem quick but compared to the depth of it, it's pretty quick.

The NCHS found relatively large differences -- actually, they're just plain large differences -- in the rates of ED visits by African-American seniors compared to whites. The differences were particularly large in the mid-

1990s. I'm not sure whether the trend is going to continue. We'll have to look at the data when we get it.

Both illness-related visits and inter-related visits increased among African-Americans but not for the population as a whole. The rate of visits among African-Americans resulting in a hospital admission increased. In part, this difference may reflect an increase in the proportion of older African-Americans residing in nursing homes, although NCHS could measure this only indirectly and it certainly doesn't account for all of it. The analysts also noted that Medicare data shows that African-Americans use of home health services increased more rapidly during the 1990s, and they suggested that returns to the ED from home health care might also be a factor in ED differential rates.

The studies also noted that the National Health Interview Survey showed an increase in the number of African-American beneficiaries with no supplemental health coverage during this period. And also they cited some other evidence that African-Americans report more problems finding a doctor.

Using data from the National Health Interview

Survey, NCHS was able to show that much of the visit rate for African-Americans was driven by multiple visits for a relatively small number of people. Neither the National Health Interview Survey Data or MEPS data or the MCBS data that we've looked at showed large differences by race in the percent of people who have a single visit. The big difference that's driving the use rate is multiple visits for a small subset of African-Americans.

We can't tell from this data what the characteristics of the heavy users are. The data that was collected by MCHS from the EDs themselves during this period didn't identify whether patients were residents of nursing homes. In the future, this information will be available and it will be interesting to go back and see how much of the use is driven by people who are living in nursing homes or other institutional settings.

Finally, I want to mention that NCHS developed a regression model using Health Interview Survey data information to examine the factors associated with multiple visits and they determined that the strongest predictor of having multiple ED visits were being African-Americans, female, diabetic and having hypertension. Again, this

supports the notion that the people who are going to the ED are, in fact, sick.

Now I'm going to turn to a little bit of information from the Medicare Current Beneficiary Survey which helps flesh this out just a little bit more. MCBS data show that the percent of beneficiaries with the usual source of care increased throughout the '90s. We talked about that in an earlier session here, as a matter of fact.

That chart shows, however, that some beneficiaries still use emergency rooms as their usual source of care and that using the ED as a usual source of care is more common among African-American and Hispanic beneficiaries than among white beneficiaries. However we can't conclude from this chart that people who use the ED as a regular source of care are the people who have a large number of ED visits. In fact, there's some evidence to the contrary, especially if you take into consideration use by people who are not living in the community.

MCBS data also shows some consistencies with the other sources to the extent that when we looked at the percentage of beneficiaries who were living in the community all year round, when asked whether they had ever gone to the

EDA -- or actually we were able to figure out whether they had ever gone to the ED -- that the highest proportion of people who had gone to the ED were the ESRD beneficiaries followed by disabled and also a very high rate for people over 85. It basically goes up with age and clearly with declining health status.

Data from the facility sample that we looked at show that more beneficiaries are using ED services on average than in the community.

What does all this mean, if anything? The available data on ED use present a complicated picture. Some, probably a lot, of ED use by beneficiaries is appropriate. Some is necessary but might be avoidable. The recent article from the Washington Post that we included in your mailing materials about managing the care of chronically ill people in the community provides some interesting illustrations of how care management may be related to ED use.

A lot of visits for individuals with serious health problems might be avoidable. People might not be getting care in the right place. They might be getting the right care and it's very difficult to sort that out from

these data. Clearly, we also found that some people are using the ED as the usual source of care and that's probably just plain inefficient.

Unfortunately, the available data don't have the information we would like or need to sort this out clearly. Over time some of the changes in the way that data are collected and the way they're organized will make it easier to figure out who's using EDs and who the heavy users are and where they get their care and how their use of ED services relates to overall use of health care. In the meantime, we're going to continue to monitor the data that are available and look for changes that might indicate new problems.

For us the next steps are going to be to explore how the use of ED services is related to quality of SNF care, to the extent that we can, in that ongoing study and also to use our post-acute care database to try to get at some of these issues of people going in and out of the emergency room and in and out of the hospital and in and out of post-hospital care. We're also going to dig in a little bit more deeply to some of the available information on how beneficiaries' access to ED services is changing.

MR. FEEZOR: Jill, thank you for a very illuminating presentation. I have three sort of data-related, just maybe asking you to look a little bit further.

First, on page three, when you talked about the ER visits, and I appreciate you doing the 55-to-64 and the 65-and above, that helps. Is there any way to capture whether there's any difference between the fee-for-service Medicare and Medicare+Choice?

DR. BERNSTEIN: There's a variable on HIS that asks about whether people are in an HMO. We can try to get that information from HIS.

MR. FEEZOR: I'd just be curious on that.

Then, the figures presented relative to a difference in access or use of ED for African-Americans, it would be interesting to see whether the over-65 is parallel to an under-65 or under-65 insured.

DR. BERNSTEIN: Use rates are higher for African-Americans in all age cohorts.

MR. FEEZOR: Finally, I was struck by the figure on page six in which it looks like actually the rate of use for the under-65 seemed to be going up, at least they're measurably higher than the over-65. I guess I'd ask Alice

or -- Jack's not here -- whether the fact that we would pay for admittances, or once that patient is admitted where you have a different way that you would pay for that under Medicare than you would under regular insurance, whether that has any bearing on that differential?

I say that and again this is largely anecdotal data, and it is for the under-65 population. In parts of California where there seemed to be a shortage of beds, physicians who want to admit somebody sooner are being encouraged to, in fact, admit them through the ED, which results in an additional $5,000 to $10,000 of startup costs there. It's almost, in some cases, as if it's by design on the hospital to, in fact, make sure that the revenues -- and I say that, that's accusatorial, but there's just a whiff of this beginning to play about in some of the tight hospital-bedded areas.

DR. NEWHOUSE: Jill, I thought these were really interesting numbers. My thoughts are somewhat along the same lines as Alan. I thought the most interesting numbers, in the sense of what I didn't know, was the charts that compared the 55-to-64s or 45-to-64s against the elderly in terms of changes. For example your chart three.

If you can do more of that and over longer periods -- and by longer periods I mean your '92 to '99 rather than '97 to 2000, although the '97 to 2000 may hint at BBA effects -- I thought that would be very interesting.

So like Alan, I wondered about for African-American/White comparisons, how stable those were over time and how different they were across age groups. I think that would help put this in context.

DR. STOWERS: I thought this was very interesting, too. I just want to be sure that we don't jump directly from a diagnosis being considered to be urgent to the conclusion that it needed to be done in the emergency room because there's a great number of diagnoses that are on the urgent list that can easily be handled in an outpatient setting that's much more economical than what the emergency room is.

One of our materials had the example of a person with pneumonia that is considered in the urgent category but every day we treat those on an outpatient basis with antibiotics at the cost of an office visit instead of several hundred dollars.

So I think it might be interesting to know here

what percentage of these are urgent visits are admitted on into the hospital or really needed that kind of care, as opposed to just being categorized in an urgent.

Another example is if a patient comes into the office and they're diabetic and their blood sure is out of control, that's considered an urgent. It's something that needs to be dealt with that day but can be very easily be handled in the office by adjusting their medication or their insulin dose. So I just want to be sure that we don't make that.

And then secondly, my point is is there -- and you kind of mention this -- how much is the lack of availability of other outpatient sources, is there a decreasing access to the physicians offices for the urgent care-type patients because of a longer time to get appointments and that all of our surveys are showing. Is that taking more of these semi-urgent patients into the emergency room and attributing -- part of these numbers and obviously an increased cost.

So I think that's a big role in here. I know you kind of touched on that.

DR. BERNSTEIN: I can add some information on that. Actually, the use of other outpatient services also

went up during this period and physician visits. People appear to be sick. That's part of the problem.

On your earlier point about the percent admitted -- Kathy may know this better -- I believe that over this period the percentage of people who were actually admitted to the hospital from the ED for the over-65 population as a whole didn't go up but it did go up for African-Americans. I'm not sure what that means either.

DR. STOWERS: I know it's somewhat anecdotal. I just know in our area -- and as you sit on hospital boards and look at it, the amount of those type semi urgent visits that are hitting the emergency room are on a tremendous increase that were traditionally handled in other outpatient, more economical settings. So it's a concern in our area.

MS. ROSENBLATT: I, too, thought this was very well done. I agree with one of the conclusions that you drew about care management. The article that was sent out also made the point that you show up at the emergency room as urgent. But if there had been appropriate care beforehand you could have avoided the emergency room visit.

It's interesting to me that diabetes showed up as

one of the really big factors there. A lot of disease management programs for the commercial population right now are focusing on diabetes. And there are statistics -- I know our medical department runs some statistics on how many emergency room visits we think we've saved by looking at a population that's under disease management versus a population without disease management. And maybe we could get some numbers like that into that. If you want contacts at Wellpoint I could put you in touch with some of the people that run our disease management programs.

Also, on Alan's point on the commercial population, I think these disease management programs are attempting to have an impact on that. Also, I think in some respects, plan design does it. I think some of HMOs over the past five years have really increased copays or even added deductibles for emergency room visits as an attempt to control it.

DR. REISCHAUER: If I understand this correctly, we're into this because we were trying to find other whether patterns of emergency department use could tell us anything about access to primary care or post-acute care. I think you've done a spectacular job showing us that the data is

both incomplete and deficient, and even if it weren't would be horrendously difficult to interpret.

And I can think of 50 explanations for almost any pattern you came up, some of them showing that there are problems out there that should be addressed and others maybe being the byproduct of good things happening like more people are getting procedures in the inpatient that have a high probability of complications after you go home and you end up back in the hospital. And ferreting all this out, I think, is an absolutely impossible task that we sort of went into this to see if there was a rich vein there to mine.

And I think that what we've shown or what you've shown is that we can get a lot of ore out, but there's no way to refine it. I'm really wondering whether this is interesting, it's very difficult to do, and we can keep doing it and keep raising all sorts of hypotheses and concerns. But if we were really interesting in sort of what the number one concern is in EDs, I thought it was the availability of them geographically, and for -- at least the non-65 population, the costs that are being imposed on people to use them.

I just wonder whether we should keep trying to get

some nuggets out of this morass or not. I think I would vote for no.

DR. BERNSTEIN: I would second that vote. I think we could actually get at what we want much more directly by looking at disease management directly and whether that results in better care management and less ED and also looking maybe at dual eligibles and how they're using ED services and looking at the post-acute care database and see what we can find there.

But otherwise, I'd be very happy never to look at these data.

MR. MULLER: The number of what I called ED divergence has gone quite a bit in the last few years which is the number of EDs that shut down for a period of time. And up to 40 percent hospitals now shut down at different times.

So whether inappropriate or not, because people come there for the reasons that have been mentioned, the fact is they're jamming up and something is happening that's consequential. Furthermore, I would point out it's been well known for a long time that a lot of people who go to the emergency room probably don't need to go there after the

fact. They know that after the fact.

And a lot of the definition of them as being urgent but not emergency is a kind of after the fact pool coding and understanding. And a lot of people don't know that when they come there. So even though the people who triage them when they come into the emergency room know they probably don't need to be there, the person presenting doesn't necessarily know that and they come there because they can't necessarily self-diagnose.

I do think we tend to overestimate the number of inappropriate emergency room utilizations from the point of view of the patient who presents himself or herself there, because they go there because they don't necessarily know any better.

The fact that it's going up so much, and the fact that so many ERs are in diversion, is not a good thing. It does have ripple effects in terms of the costs of the system. So I share with you the difficulty of trying to understand this data. If the number of ER diversions keep going up, and in many parts of the country they will continue to escalate, and there's evidence from other countries that they're going up even more because there's

even a shorter supply in other countries of services than there are in the U.S. I just think it's something that we'll have to come back on at some point.

I grant all the points that have been made about the lack of appropriate data. The problem is not going to go away, however by saying we can't understand it at the moment.

DR. REISCHAUER: What we were here trying to do is to say do the patterns that we see in the EDs tell us something about problems with access to acute care and post-acute care elsewhere? I'm just saying I think the answer to that is we don't know. We can look at this a whole lot longer and won't know. So let's focus on a question which maybe we can get the answer to.

MS. RAPHAEL: I tend to agree with what Bob is saying. I mean I am aware of the issues around increased use of the emergency room. Hospitals that I'm familiar with have, on any given day now, 40 people waiting in the emergency room to get beds in the hospital and a lot of people backed up waiting five, six, seven hours just to be seen in the emergency room. So there's no doubt that there are some trends there that are important.

But when I read all of this, what it reflected to me is problems in the overall health care system in the sense that I don't think the issue is access to post-acute care. To me we're sending a significant number of people backed from home health care to the emergency room. And why we sending them back and why are they going to the emergency room on a regular basis?

I think that it really just has to do with the whole issue of how we're managing people with chronic disease who have many, many needs and the lack of continuity and integration in our health care system. And there's no doubt about the fact that I've seen in the minority population in New York City very heavy reliance on the emergency room as sort of the primary care. And it has a lot of costs to the system in many ways.

But I just don't think that this is a fruitful endeavor in terms of trying to really see whether or not there are important access issues, because my experience is that the issue isn't so much around access to the emergency room as use of the emergency room as a default because of other issues in the health care system.

MR. HACKBARTH: The there anybody who disagrees

with Bob's prospective on this, that this is not a good way to try to look at monitor for access problems. There may be interesting issues but they are beyond the scope of this meeting.

DR. NEWHOUSE: I was a little more dovish than Bob. I thought that some of the problem were mitigated by using the 45-to-64s as a control group and looking at trends. Now to be degree that this says the differences are caused by things really improving in the commercial population, and they've kind of stayed the same in the Medicare population, that objection certainly remains and is an important objection.

But I thought these were at least interesting data. They certainly did raise some questions and they maybe would provoke somebody else to go look at them even if they didn't have any immediate policy ramifications for us.

MS. DePARLE: I don't disagree but I had a question and a comment related to what Bob said, and also related to what Joe said. How much is Medicare spending right now on emergency department care?

DR. BERNSTEIN: Actually it's almost impossible to be known. This is a claims data problem. You'll at least

be able to figure out what they're spending under the new APC system over time because the coding includes whether it's an emergency department visit. Right now you can't sort them out from regular outpatient claims.

MS. DePARLE: Then I guess I wouldn't disagree with what Bob said. My sense, from when I looked at this before was that it was not that significant a proportion of Medicare spending, which in my mind then supports what you suggested, Bob, about given this isn't a big --

DR. REISCHAUER: Not because we were worried about that, because we thought it might be the canary in the mine, right?

MS. DePARLE: So I guess where I'm going is I agree with you, but I wonder if we should try to develop some sort of a recommendation around the data that's needed to try to help the agency to get the kind of data that is needed to understand this better. If the Data is that deficient are there recommendations that we could make?

My other comment relates to what Joe said and also what Ralph was saying earlier. The Robert Wood Johnson Foundation has just funded a major project on this subject, what's wrong with emergency rooms? Why are there, as Carol

said, 40 people waiting in all these different hospitals? And they're doing demonstrations and it's a major project. We might want to just take a look at where they're going with that, but they're trying to answer some of these questions not from a Medicare prospective.

MR. HACKBARTH: I haven't forgotten it I've got three other people on the list here, and I'll get to you in a second.

If, in fact, as Bob puts it, these sort of data do not serve as the canary in the mine, it raises for me a question of how we deploy our staff resources over the next few months. There may be lots of interesting questions that we can delve into at a later point. But if they're not really good for the immediate purpose we had been looking for, to monitor access to care, what we may want to do is set it aside for right now and potentially look at this as a topic later on for independent analysis but not consume the resources right now while we're trying to do our March report and work towards the June report.

DR. NEWHOUSE: I think you could potentially consider putting what you have here in the June report.

MR. HACKBARTH: Just as it is, without --

DR. NEWHOUSE: Maybe some minor touching up here and there, but not spending significant major effort in refining or exploring further with this. I thought this was new data. Maybe lots of people know this. I didn't know a lot of -- I mean, I knew the differences cross-sectionally, but I didn't know the time trends against the elderly versus the non-elderly.

DR. MILLER: I could see going that route as well and I also want to just touch back on Nancy-Ann's point, and that might be the introduction to it, is we could put this in the report, point out the complexities and how the data doesn't link up particularly well and make a recommendation about where Medicare or anywhere else the sources of data could be collected, just to point it out.

I think, just to finish the thought, one of the things that I've been thinking about -- and this touched on it -- is the notion as we regularly go through our analysis, we're going to find this all the time, data that's missing, those kinds of things. And as a regular feature we might think about, just as we go out, is to make recommendations where there are deficiencies in information.

MR. HACKBARTH: So you're suggesting that we may

want to do something in the June report without a lot of additional elaboration?

DR. MILLER: I'm certainly open to that.

MR. HACKBARTH: So why don't you take a look at that question along with the staff. I have Alan Nelson, Pete, and David Smith and then we need to move on.

DR. NELSON: My point has been made.

MR. SMITH: My point has been substantially made so I won't do it again.

I generally agree with Bob put I don't want to lose track of what Carol and Alice said, that what jumped out at me in this work was again what we've looked at several times in the past of the importance or the failure of Medicare to provide a case management apparatus. And while a lot of folks who end up in ERs may need to be there they probably didn't need to be there if the case management system hadn't broken down or didn't exist. And I just want to underscore the importance of trying to take again a look at -- I think at one point we even considered recommending that Medicare add some sort of a management benefit. It may be time to revisit that question.

DR. NEWHOUSE: If I may make a comment on the

data, actually my problem with that is to really get where we want to get I think you have to get into appropriateness which involves looking at charge, which is beyond these data systems. And also it would involve comparing the over and under 65 because it's hard to make sense of the over-65, unless is this a system-wide problem or is it specific to Medicare. And that again tends to go, you put that together with the appropriateness, and it gets very hard.

So my reaction actually is it would depend on what specifically we were recommending about the data system as to how useful it would be, at least for our purposes.

MR. HACKBARTH: Think you, Jill.

Our last item before lunch relates to access to post-hospital care. Sally is going to report on the results of a focus group that we conducted to try to get some information on that topic. Sally?

DR. KAPLAN: Good morning.

As part of our ongoing effort to monitor beneficiaries' access to care and to assess the adequacy of Medicare's payment for post-acute care under PPS, we invited 15 hospital discharge planners to participate in an all-day focus group. The purpose of this presentation is to inform

you of the results of their discussion.

The focus group participants were from 15 hospitals located in 14 states. Five were registered nurses, 10 were social workers. All of them have been on the front lines of discharging patient from hospitals for five to 10 years or longer. Five of the hospitals are located in rural areas. Of the 10 urban hospitals, eight discharge to both urban and rural areas. Two of the hospitals have no post-acute care or hospital-based post-acute care themselves.

As you can see from the slide, home health and inpatient rehabilitation units are tied for the most popular post-acute care at the moment.

The discharge planners discussed the impact of the SNF and home health PPS's on the discharge planning process and on beneficiaries' access to post-acute care. I want to point out that the results of the focus group's discussion are not a definitive statement about beneficiaries' access to post-acute care. They give us some clues.

We are all familiar with the financial incentives of the hospital PPS and that hospitals are encouraged to discharge patients as quickly as possible. That creates

pressure on the hospital's employees who are responsible for planning the discharges, clearly the discharge planners.

The post-acute PPS' have added to the pressure because under these payment systems, post-acute providers have become more selective about the patients they will accept.

Discharge planners said that in general beneficiaries have access to home health care although patients in rural areas who need therapy may have delays in placement. The discharge planners told us that post-PPS, home health agencies are reluctant to accept patients needing expensive supplies such as wound patients or patients needing tube feeding, because home health agencies are paid the same for supplies regardless of patient need.

Home health agencies have changed their behavior under PPS by substituting physical therapists for occupational therapists, by reducing social work visits, and reducing the length of time diabetics are trained in self-care, according to the discharge planners.

Focus group participants that patients needing rehabilitation care have no difficulty accessing SNF care because SNFs are paid generously for this type of care. As

a reminder for you, rehabilitation makes up 75 percent of the SNF days. If we define difficulty in placement as a delay of at least one day, the discharge planners told us they encountered this situation 5 to 25 percent of the time. In some cases, non-rehabilitation patients stay in the hospital for significant amounts of time because discharge planners cannot find SNF placements for them.

The discharge planners told us that post-PPS difficult to place patients were those that need dialysis, expensive medications, tube feeding, or have wounds requiring wound vac. They also mentioned patients with infectious diseases, mental illness, or cognitive impairment but these patients were difficult to place before the PPS.

As far as other post-acute care, the discharge planners told us that they use long-term care hospitals when SNFs will not accept patients. They also told us that under PPS some rehab facilities try to limit admission only to patients who will go home after their rehab stay. Some rehab facilities are no longer taking patients for observation, according to the focus group participants.

To wrap up, in the absence of other information we had a focus group of 15 discharge planners to get an idea of

how beneficiaries' access to care has been affected by the post-acute care PPS's. The incentives inherent in the hospital PPS to discharge patients has quickly as possible has always put pressure on discharge planners. Now that Medicare has more prospective payment systems, discharge plans have to contend with the effectiveness of those new PPS's, in addition to the pressure from the hospital PPS.

For beneficiaries needing home health access largely looks good under PPS. As the SNF PPS is current configured, beneficiaries needing rehab services have no problem accessing care. For patients who need non-rehabilitation care in SNFs, placement is sometimes delayed for at least one day. Those were the opinions of the 15 people in our focus group. This information will be reflected in our discussion of payment adequacy and a chapter on access in the March report.

I'm happy to answer any questions.

DR. REISCHAUER: Sally, did you get the feeling that these individuals were comparing the current situation with what it was four years ago and so this was a relative statement that they were giving?

DR. KAPLAN: Yes, that was very clear. In fact,

the facilitator clearly asked, we want a comparison pre-PPS to post-PPS.

DR. REISCHAUER: So these were all people who have been in these jobs for a considerable length of time?

DR. KAPLAN: Yes. We made sure that when we invited the focus group participants, we made sure that they had been doing discharge planning long enough to have experience pre-PPS and post-PPS.

DR. REISCHAUER: Do you have any idea what fraction of hospitals had some post-acute care arrangement? I mean, a home health agency, a SNF, or whatever? Because this group is heavily in that business, I would think, relative to the average for hospitals.

DR. KAPLAN: Well, I don't have the statistics here. We hope to be able to give that to you at some point, as to how many of the hospitals have post-acute care and what type of post-acute care. Is that what you're looking for?

DR. REISCHAUER: Yes.

DR. NELSON: I'm really glad that you pursued this, Sally. And I think that discharge planners can be an important continuing source of information. I think it

would be really nice if some of the key questions that were addressed could be more systematically approached with some sort of survey so we aren't just relying on a focus group and so that we could get some longitudinal data using the same questions over time.

I guess my question had to do with how much consensus you sensed on the part of the focus group members. Sometimes those opinions will really be quite broad and not shared very tightly. On the other hand if this group of people all seem to nod their heads simultaneously around some of these critical issues, that would be of more value.

Did you have a sense that the opinions were pretty uniformly shared? Or were they less shared commonly?

DR. KAPLAN: I think there was very strong consensus on home health. I think there was a little less consensus on SNF. It was clear that they all agreed that rehab patients have no problem getting SNF care. That was made very clear.

On the percentage of patients who might have placements delayed a day or longer, there was less consensus and that's why we gave you the range that we did. That may be a geographic issue and this is only 14 states out of the

50. But definitely I would say there was strong -- and also strong consensus on the pressure that is on them, the pressure that they're experiencing in their jobs. There was lots of consensus on that.

DR. STOWERS: This was a good look. I had a little bit of a question on the rural thing. When we talk about was it the same before or after. In other words, did the rural thing change after the PPS, or was this something that held pretty steady? And then you said that there was a little more problem in the rural area processing versus the other. And I wonder what significance that would have on this extended differential payment that we had? Would that indicate that that may need to stay in there as a policy question? I just wondering how strong this rural thing came across.

DR. KAPLAN: I think I'm concerned about making any strong statements based on the focus group, and I think that the work that we're doing, the other work that we're doing on payment adequacy may have more weight when you're considering things like the 10 percent add-on for rural beneficiaries using home health. I would be much more comfortable in relying on the other information that we're

going to be using than 15 people's opinion in making that decision.

DR. STOWERS: The other question I had, whether we say it's significant or not, is the 25 percent thing or the one day delay, that kind of thing. A one day delay or change in the length of stay under a PPS to the hospitals we work with would be a very significant cost item if you were changing it that much. I just was curious if somewhere we're playing this out a little bit, that we don't look at what the actual costs are in having these kind of delays and that kind of thing.

DR. KAPLAN: One thing that was said about the rural SNFs, and I don't have a sense of consensus on this. And this primarily came from the discharge planners that worked in the urban hospitals that were discharging to both urban and rural SNFs. They seemed to feel that the urban SNFs would take a patient who needed a higher level of care than the rural SNFs would, and kind of indicated that some of the rural SNFs may not have felt as confident about their ability to take care of patients that urban SNFs would take care of.

MS. RAPHAEL: I had one observation and then one

or two questions. To me, the most important result of what you have done thus far is something that I have observed and I think it's something we have to be wary of, which is we may have created a post-acute care system that's very much geared to rehabilitation. And we have to really wonder about whether or not there will be continued access for extended stay medically complex possibly cognitively impaired beneficiaries.

When I look at the incentives, I have to believe that in some way, either wittingly or unwittingly, the incentives benefit taking rehab -- short-stay rehab patients -- in almost all parts of the post-acute care sector. I think that is a larger policy issue that we should highlight in all of this.

You say that for the rehab facilities you have to be able to go home for them to even admit you. That's a high bar, that you have to be able to go home in a short period of time actually. So I think that is something I would like to see kind of pulled together more.

Another thing that came out from your data so far, which I found interesting, the long-term care hospitals and the SNFs are interchangeable in the minds of these discharge

planners. Maybe I'm reading too much into it and I wanted to get that clarified, but that would be important to understand.

Then I guess I wanted to know what your plans were for at least taking a look at access for the 50 percent or so in some parts that don't come from the hospitals but come from the community. I know you've looked at this but is there any way at all you think we can get any information on access from the community?

DR. KAPLAN: Let me first address your question about the long-term care hospitals. I did not get a sense that they were substitutable. What I got was that pre-PPS, when SNFs were paid on a cost basis got pass-through for ancillaries, which means drugs in addition to other ancillaries, that they were taking patients at a very high level that might be the patients that would be at the lower level of what the long-term care hospital patient was taking.

Now the SNFs really don't want that patient because we know the problems with the non-therapy ancillaries with the SNF payment. So if they can they discharge those to long-term care hospitals.

Long-term care hospitals were most often mentioned with vent patients. The work that we have done in the past have shown that ventilator patients never made up more than 1 percent of SNF patients, from 1995, which was pre-PPS. It was less than 1 percent of all SNF patients. So I think we're talking about a select number of patients in addition to a select number of hospitals.

On the 50 percent of patients, I just want to remind the commissioners, that's not 50 percent of all patients, that's 50 percent of all home health patients that are not post-hospital. We believe that was pre-PPS. This is a dilemma of how to do this. The inspector general did a study last year, which they have stated they will not repeat because they were not confident of the results, to try and assess access for community-referred home health -- beneficiaries who live in the community referred for home health and whether they had access to home health care.

They did an extensive study, used a methodology that MedPAC actually recommended that they use, which included talking to positions, talking to AAA's, Area Agencies on Aging, talking to all kinds of advocates. And they felt that they did not get very good response. The big

problem was that the physicians, the AAA's, and the other advocates do not understand what Medicare's rules are about whether you are eligible to get home health care.

I think that this is something that maybe we need to discuss about whether we want to make the investment of resources to do a similar type of study or if there's another way to approach this. I frankly have not been able to think of another idea of a good way to approach it to get really good information on this.

So I'd be real interested in the Commission's input on that, either now or at a later time.

MR. HACKBARTH: I don't have any suggestions on that, Sally, but can I go back to the issue of delays in placement for certain types of patients? If they are delayed in placement but remain in the hospital, as Ray points out that could have financial implications for the hospital but it may not necessarily be a bad thing in terms of the care delivered to a patient with some significant issues. So it's not, per se, an access problem to high-quality care necessarily. Maybe more of a financial issue for hospitals. Did you have some reaction to that Sally?

DR. KAPLAN: I agree with you. This, of course,

is the discharge planners' perspective and they work for the hospital and the hospital is putting, what sounded to me like tremendous pressure on them to get these people out of the hospital because they cost.

MR. HACKBARTH: I may be speaking to the larger audience here, our guests as well as commissioners. I worry sometimes that people look at things and they glom onto it as oh, this is the access problem. People aren't getting care that they need. And in this particular case it may not have anything to do with patients getting the care they need. It may be more of a financial issue for the players in the system. I want to avoid misinterpretation.

DR. NEWHOUSE: Sally, did you talk to anybody in M+c organizations? That strikes me as a way around the issue that you only talked to the people who are employed by hospitals since the M+C organizations have quite different incentives. So you might talk with people that are on top of the post-acute use there.

MR. HACKBARTH: One other question, Sally. For rehab patients, the placement is not a problem, but for patients with other certain problems it is. Refresh my recollection on how the relative prices, as it were, were

set for the different types of services. And could that be something worth looking at?

DR. KAPLAN: I'm glad you asked that question. In fact, Dr. Reischauer raised the issue at the last meeting that one of the things that we needed to look at was whether we could better target the add-ons. I think this is another piece of evidence that the weights with the SNF PPS are problematic.

The way that the RUGS, which is the classification system for the SNF PPS works, is it's a hierarchical system. If the provider, if the SNF, is able to deliver rehab to a patient, that puts them into a rehab group. It's about a matter of what the patient needs, it's a matter of the services that the facility delivers. This is one of our problems with this PPS.

Rehab patients go to the head of the line so that even though you may need extensive medical care and you are receiving rehab, you are a rehab patient. And the rehab rates are higher, or were higher at the very beginning, than for the non-rehab patients for most of the people in the SNF.

The add-on added 20 percent to the non-rehab. It originally added 20 percent to three rehab categories but then they basically spread that among all the rehab categories. So they're now receiving 6.7 percent on top of the rate that they were receiving, and the non-rehab are receiving 20 percent.

But to me, this is evidence that even with that 20 percent, those rates are not where they should be. We are planning to look at that. Unfortunately, we're not going to be able to look at it for the March report. There's just too much to get done for the March report and too many problems in getting it done. But we are planning on doing that for the June report because we agree with Dr. Reischauer, that would be a huge contribution for the Commission if we could find a better way to target the add-ons.

DR. WAKEFIELD: I just want to comment on your last comment, Glenn, access to services and is this really an access issue, depending on how one comes to it. I would defer to the colleagues who are very familiar with post-acute care. But at least I can tell you, based on my limited experience what Medicare beneficiaries in my own

family, in seeing them in hospitals and then seeing the care that they get once they've been moved into that outpatient facility. That care strikes me as really quite different.

So if it's a post-op, post-surgical couple of days, for example for back surgery. The care they're getting in that hospital is very different from, at least what I've observed, from that very aggressive, almost restorative set of interventions that they've received when they've moved into a post-acute setting. And I only raise it in response to your comment. I don't know that they're equivalent in that respect, but I would suppose that folks who work with those populations would. But it didn't strike me that way as a consumer.

DR. STOWERS: I'll extend on what you're saying, and my second point is that it's not black and what on the access because while not all hospitals are at 100 percent capacity bed-wise, sometimes we are waiting on these beds to get cleared out, either for shorting of nursing staffing or that kind of thing. So it is sometimes an access there, just that the hospital can't handle the number of patients or the admission. That kind of feeds off of Ralph's diversion from emergency rooms and so forth.

One of the reasons for that is no bad capacity so during those seasonal times that that happens, this lack of being able to get these people out to these other facilities can be a very significant access issue.

DR. NELSON: I also was responding to your comment, which I inferred you were saying it's a hospital cost problem not so much a quality problem because the hospital will keep them.

Did you have sense that if they were having difficulty in placing a patient for home health care for example, that they would just send them home without it?

DR. KAPLAN: No.

DR. NELSON: So the hospital took care of the patients to the degree they --

DR. KAPLAN: No, they basically maintained that they had some other creative solutions, some of them had some other creative solutions, but generally when we asked what happens to these patients if you can't place them. And they said they stayed in the hospital. That was made very clear. People are not being put out on the street. They said sometimes families would choose to take a patient home with home health care maybe when they needed to go to a SNF,

but the hospital was not making that decision.

DR. NELSON: That's good.

MR. HACKBARTH: Thank you Sally.

We now have our public comment period, of about 10 minutes maximum. Before we start that, I want to remind people that we are changing our process for distribution of the agenda for the meetings in advance. We're going to send out e-mail notification of the agenda. If you want to be on that e-mail list you need to sign up out front if you haven't done so already.

Any comments from the public?

Okay, we will reconvene at 1:30.

[Whereupon, at 12:17 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:35 p.m.]

MR. HACKBARTH: Our first topic this afternoon is examining growth in the volume of physician services. Obviously one of the central reasons for these sustainable growth rate system is concern about growth in the volume of services, so Kevin and Joan are going to report on some work is to examine as best we can exactly where the volume is occurring or not occurring.

Kevin?

DR. SOKOLOVSKY: Today we want to present the first part of an ongoing project analyzing increases in the volume of physician services for Medicare beneficiaries. Looking at the distinction that was made this morning, in today's presentation we're not talking about the baseline volume of services, but rather increases on an annual rate in volume of services.

Despite the continuing interest by Congress on the subject, there is surprisingly little information available on the extent and character of volume growth. There are two reasons why we want to start looking at the issue at the present time. The first is that the Commission expressed interest in looking further into the subject at the

commission retreat this summer.

But the second reason is that the BBRA required the Agency for Health Care Research and Quality, AHRQ, to prepare a report for Congress on changes in the use of physician services by Medicare beneficiaries. This report is due December of this year. At that point, MedPAC will have six months to evaluate report and make recommendations to Congress. So this is our attempt to prepare to analyze and evaluate that report.

What we're going to do today is to talk a little bit about what is known about volume growth. I'm going to give you a brief introduction to that. Then we're going to look at the extent of volume growth from 1999 to 2001, and look at how that growth differs by specific services provided. I want you to note here that this information is updated from what you received in your briefing materials. There's an extra year of data to be analyzed.

Finally, we'll discuss our plans for future work.

Policymakers became concerned about volume growth in the 1980s when Medicare spending for physician services was growing at an annual rate of 12 percent. At that rate of growth spending was actually doubling every six years.

During this period, volume of services per beneficiary was growing at an annual rate of 6.6 percent.

As you can see, all do expenditure growth was high throughout the decade, the relative contribution of payment increases and volume growth varied. Through the first half of 1985 expenditure growth was fueled by both payment increases and volume growth. But from July 1984 to 1986 there was a freeze on payments, but because of growth in the volume of services there was a continued increase in expenditures throughout that period.

Expenditure increases per beneficiary slowed to 6.2 percent from 1992 to 2000 and overall volume growth slowed to an average annual rate of 1.4 percent. However, even during this period the rate of volume growth was not uniform and volume growth increased at higher rates for some specific services in this period including arthroscopic surgery, echocardiograms, MRIs, and angioplasty.

In the scholarly literature, increases in the number of physician services are accounted for by a number of factors, some of which are listed there including aging of the beneficiary population, increases in physician supply, increases in services that are provided to

terminally ill beneficiaries, increases in supplemental health insurance, and increases in innovation and diffusion of medical technology.

In previous MedPAC work we've looked at some of these factors and found that most of them have only limited effect on annual rates of volume growth. However we have not recently studied the role of technology innovation and diffusion on volume growth. Many analysts believe that technological change has been the key factor driving volume growth in physician services, although they may disagree about the value of some of the increased services provided.

To examine these issues further I will now turn to Kevin.

DR. HAYES: What we've done here is to take a first step toward trying to increase our understanding of volume growth, and we've done so by looking at changes in, and use of service by type of service.

Before we get to the numbers I just wanted to say a few things about the structure of this table that you see here. The first has to do with our measure of volume. It's really the same measure that we used in the Commission's June 2001 report to the Congress on Medicare in rural

America. There we had a measure of service use, volume, whatever you want to call it, which was composed of two things. First was just the count of services, and the second was the relative weight assigned to the service under whatever payment system was applicable. In this case we're talking about the relative weights that are in the physician fee schedule.

So by looking at volume in this way, the changes in volume that we see really represent two things. First is just changes in the use of services by Medicare beneficiaries, but also changes in their intensity. So you can imagine as an example, an intensity change would be going from a short, low complexity office visit to a longer, higher complexity visit. But in any case, these volume growth numbers that we see here capture both effects, the change in the number of services as well as their intensity.

The other thing I'd point out here is that we are trying to look in some detail at volume growth and we've used a service classification scheme that was developed and is maintained by CMS. So at its most general level you see the categories of services that are shown here in the left side of the table that would include, first, evaluation and

management services which is primarily visit services, office visits and the like; imaging, which includes things like CAT scans, MRI scans, cardiac catheterizations; procedures would be both major and minor surgical procedures as well as some endoscopic procedures like colonoscopies; and finally, we have a category called tests which is mostly lab tests, but it also includes some other things like electrocardiograms and cardiovascular stress tests.

Joan mentioned that we've added another year's worth of data, so you can see in the middle column of this table that we have growth rates for 2001, and then the far right column shows the average annual rate of change for each category.

Two observations about the numbers themselves. The first is that you can see some volatility here. It's not unusual. We've been looking at claims data, using claims data to analyze volume growth for a long time, and it's not unusual to see some fluctuations in the numbers. In this all services category, for example, you can see it going from 3.1 percent down to 2.2 percent. To understand more about why those changes are occurring, you've got to step down to another level in the classification scheme

which we'll get to get a second.

The other thing to point out about this table is that we see some relatively high volume growth for the category of services called imaging. There we don't see much volatility, but the growth rates for both 2000 and 2001 are about in the neighborhood of 9 percent a year.

So to look further we need to just step down another level in detail, so in the case of that evaluation and management services category we can look at specific types of visits, for example, office visits, visits to patients in the hospital, and so forth. Table 1 that was in the paper that we sent you for the meeting has that kind of detail for all the different categories that were shown.

This particular table shows some of the detail for that imaging category. We picked the services that are shown here for two reasons; they all have two characteristics. First, they are responsible for relatively high proportions of total volume within that imaging category. The second is that they all have relatively high growth rates in terms of volume. That then helps us understand what's pulling up that growth rate for the imaging category by looking at these high volume services.

You can see -- the numbers pretty much speak for themselves. Just about all of them are in double digits. We'll talk in a second about future work that we'd like to do on this topic, but one question for you today is just what else would you like to know about these numbers. We can do some more detailed work in terms of looking at changes by geographic area, site of care, and all that kind of thing. So just let us know what you're thinking about there and we'll do it. This is a topic for the June report so we have some time to do some further analysis.

The next slide also points out that we did see some decreases in volume for some services. They're in a range of different categories. Visits, a couple categories of visits. Hospital and psychiatric visits saw some decreases in volume; standard chest imaging and so on. We're not real clear why these decreases occurred. One possible explanation that I think would apply to the coronary artery bypass graft services has to do with substitution among types of service. Not shown on any of these tables, but in the paper that we sent you you could see some growth in the volume of angioplasties which are a newer, less invasive procedure, as you know, for treatment

of coronary artery disease. So that could be the drop we see in the open heart procedure is because of the emergence of that other procedure.

So we've taken a first step here, and next we want to do some further analysis and we're looking for your ideas on that. We'll also talk to some experts in the field and try and get some understanding of why the volume changes are occurring, the ones that we see. Possible explanations range from diffusion of new technologies, changes in indications for use of particular services; possibilities of some errors in payment rates, payment rates too high or too low; changes in coding patterns; simple public awareness of the different procedures. All these are possible reasons why we're seeing the volume growth that we see here.

In the way of future work, certainly one thing we want to do is to extend the analysis to include data through the first six months of 2002. We also want to update previous analyses we've done which show changes in volume by site of care. We'll be, simultaneous with work on the chapter for the June report, we'll also be reviewing and commenting on the AHRQ study that Joan mentioned. We want to look at service use by geographic area, to the extent

that our claims data allow us to do that. Other analyses, whatever you can suggest there, we'd be happy to do it. Then ultimately as part of all of this process we want to come out of the other end with, we hope, some recommendations for policy.

That's it.

MR. MULLER: In looking at the imaging numbers, in one of the hypotheses we've looked at before and you mentioned the change in indications for which a procedure is used, is there any way of correlating the imaging incidents with other utilization to see whether in fact the hypothesis that it's being used for new indications can be looked at any more fully?

DR. HAYES: One way to look at that would be to look at the age distribution of beneficiaries and see who's using what.

MR. MULLER: I was looking at the utilization of other services in a time period, and so forth. I don't know what one would find, but just in case if in fact -- I think part of the reason that the imaging exploded is that the imaging devices in fact got a lot cheaper. So instead of $2 million a pop you could get them for lower than $2 million.

They went down quite a bit that allowed diffusion. But if there's any way of looking at -- it probably wouldn't necessarily relate to hospitalizations so I'm not sure what I'm looking for, but maybe do some data mining to see what else it might correlate to in terms of utilization of Medicare services.

DR. HAYES: We can certainly look at the diagnoses of beneficiaries who are receiving these services. If we wanted to get into some fairly complex analyses we could look at -- you mentioned hospitalization. We could think about some of these services in the context of an episode of care that beneficiaries are experiencing.

MR. MULLER: My sense would be more in the outpatient front. That's why -- I don't know what the other people around the table think but insofar that we've been speculating that as these technologies come along it's not just that it's an added us. It's not just like a CT on top of a chest x-ray, but it's also that new populations are served with the services that previously -- where they were not being used, If there's any way of trying to find out what other ways there are of describing the people to whom these services are now being offered. My guess is it will

be on the outpatient front rather than inpatient, but I'm not sure of that.

DR. HAYES: The beneficiary characteristics that we have available to us in the claims data include things like place of residence age, sex, diagnosis, and race.

MR. MULLER: But the diagnoses would just be a inpatient.

DR. HAYES: No, even for outpatient claims there is diagnosis identified.

DR. ROWE: Thank you, Joan and Kevin, very much. Just a couple of suggestions on the analysis. One is, this may be an area in which it's worth carving out the disabled from the elderly and seeing whether or not we're seeing the same trends in each. Five million-plus disabled is a non-trivial piece of the pie. That would be interesting.

Then with the existing residual elderly population, I think it would be interesting to age adjust this, because the relationship between age and utilization is very, very steep. There may be, even over a period of time, a very small, modest change in age. I don't know if there is or not, but 65 years after the Depression the number of -- the birth rate fell during the Depression.

Sixty-five years after that the number of people entering the cohort 65 and older actually falls for a while. There are more old-old, fewer young-old. I don't know.

Or you might just separate the old-old from the young-old and look at 65 to 75, and then 75 to 85. Some correction or adjustment to make sure that we're not been misled to any degree by age. I'm not certain that we would be, but somebody would ask.

The last thing I would suggest is it might be worth going back and looking at specific areas in which payment has been reduced significantly for some procedures, whether that's colonoscopy or whatever his. One could hypothesize that there might be two different effects. One is a reduction in the volume of those services, since to whatever extent there's a financial incentive, there's less of that. The other is an increase in the volume of those services because you need to do more of those to reach a certain income level, whatever.

It might be interesting to have a couple examples of the effect of payment change on volume because I think that question might come up as well.

Thank you.

MS. BURKE: My question -- two things really. One, thank you. I think you guys did a terrific job. But one small note on the front page and the question that you ask about whether -- a suggestion that we may include geographic variation. I would strongly argue that we should because I think that understanding that and knowing that going forward would be quite useful.

In that context, one of the factors that was not referenced at all as having an influence on volume was the issue of litigation and malpractice. There has been a great deal of discussion of this over time with some suggesting that it has little real impact. But to the extent that you are in fact going to be able to do any geographic analysis, query whether there is the opportunity to look at whether or not there is an impact on volume in states in which there is a history of litigation or they're particularly litigious around specific specialties.

Again, because of the population we're dealing with, some of the most obvious, Ob/Gyn and so forth, would perhaps not be. I mean, Gyn would be; Ob might not be as relevant. But it would seem to me that the extent to which we can look at whether in fact that there is a factor that

ought to be considered, or whether in fact it's a moot issue. It comes up all the time and to the extent that we have the data, I think it's worth asking the question. We know where the awards have been. We know some sense of that. I think it's worth thinking about.

DR. HAYES: I've given some thought to that issue and it's a pretty complex one, and I'll just say now that we do have a measure available to us of that, which is the GPCI, the geographic practice cost index for malpractice insurance, professional liability insurance. So we'll look into that and see if there's something we can do with that.

MS. BURKE: Again, I think the extent to which you can also look at it by specialty, if GPCI will allow you to do that, because arguably the malpractice rates would reflect the award history. Obviously one would imagine that they go up as awards go up. But I do think it does vary the profession, and it may not be across the profession widely but may be pockets where it has it an impact and may then reflect volume in the terms of the frequency with which one does tests in particular areas. It may have some impact.

DR. HAYES: Unfortunately, the GPCIs that we have are for all services. They're kind of across the board.

Now we know, of course, that professional liability insurance is more expensive for some specialties. Neurosurgery in this population is particularly important. But, yes, we'll do what we can. Thank you.

DR. NEWHOUSE:

First a comment and then a suggestion. The comment is that to interpret this stuff you really need something about appropriateness; you know, is this is a good thing or a bad thing? This is pretty silent on that score. Now there's some old RAND work from 20 years ago that shows appropriateness actually doesn't vary very much with overall rates, but that's at a point in time. It would be nice to -- not that you to could do it, but nice to repeat something like that to look at changes. We might want to suggest that.

Then the comment is to reinforce what others have suggested on looking at it by age but put a different twist on it, which is you had a statement when you talked about growth in imaging that none of the technologies involved that were growing were new. But what may be new is that as people get better with procedures, or procedures get less invasive such as angioplasty, that the threshold for doing

them goes down. Therefore, for example, you probably are not doing a cardiac cath for the sake of the cath, you're doing it because you're thinking about revascularization.

There was some very interesting data in a Health Affairs article in '99 of Vic Fuchs that actually came from Mark McClellan that showed the growth rates of several procedures over a seven or eight-year period in Medicare for 65 to 70-year-olds versus over 85. The growth rates were enormously greater among the over-85, largely -- their interpretation, which I agree with, was that it was this falling clinical threshold for doing the procedure. Now I would call that a form of technological change or learning by doing.

So the fact that there is a code for a procedure that is performed in the Medicare population doesn't really say it's not technological change that's going on. But in any event, just showing where the increases are occurring age-wise would be useful.

Actually in terms of the Medicare use my recollection is that Medicare use actually peaks around age 75 and is somewhat less in the younger group and somewhat less in the older group, largely because physicians are less

aggressive with the older group. So I think that's why Mark did 65 to 70 versus 85 and over.

There could even be technological change with imaging going on. Presumably resolution has been getting better. So the fact that I was doing an MRI before, maybe I do more of it now because I can find out more.

But I enjoyed reading this stuff. Nice to see it.

DR. HAYES: If I may, just on that matter of the resolution business, the improving resolution. That was part of the reason why we wanted to consult with some experts in the field, just to get an idea of what the technological improvements have been that might have stimulated this further use of the services.

DR. NEWHOUSE:

There was this comment that the use of well-established technologies is increasing and it's not your grandfather's MRI machine.

DR. ROWE: Just a clinical comment on this. I think that part of the change -- I support strongly Joe's notion. Part of the change is a reduction in the age bias. When I was graduating medical school in 1970 I'd never see an 85-year-old man getting a heart operation. Now it's very

common. The new technologies -- there were plenty of younger people to operate on, if you will, and not that many cardiac surgeons.

But some of it is also related to technological change that might not be completely apparent. For instance, with respect to many of the surgical procedures that are conducted much more frequently in older people now than they were before, I believe the technological change has been in anesthesia, not in the surgical procedure. The anesthesia is operating at six Sigma levels in terms of safety and has gotten much, much more sophisticated with respect older individuals, and that has made them less risky. So I think that's a part of it, and that's one of the considerations that really should go into this.

I also think that the reasons that older individuals are less likely to be operated on, like after age 75, might be an age bias, but it might just be good judgment, because an older individual is more likely to have comorbidity, more likely to have some other diseases which increase the risk of an adverse effect or a complication from a given operation. So the equation of benefit over risk in somebody at age 70 may change at age 80. Not

because they're 10 years older, but because their clinical condition has changed. Therefore, the correct judgment is not to expose them to the risk because it's not worth the benefit in that physician's eyes.

So I just think sometimes when we talk about some of these age differences we assume age biases, which as a gerontologist I always assume. I see age bias behind every tree and under every rock. But I think that there are these clinical changes in the population that might be explanatory as well. So if we write about that we have to provide some balance.

DR. NELSON: I have a comment too and then a couple of suggestions. The comment has to do with me appreciating the neutral tone in this, neither implying that the increase in volume is good or bad. I think that's some reference to medical necessity, or in this case perhaps cost effectiveness might be useful, but that can be a really slippery slope in getting into how much a quality-adjusted life-year should be worth, and also subjective issues like whether the MRI is necessary or not depends on whether you've got the headache are not. So you have to be awful careful when we get into that to not overstate conclusions

that society as a whole may not be ready to support.

With respect to the factors affecting growth, I think we need to recognize screening procedures that have been added to the benefit package and that are undoubtedly impacting it. Colorectal cancer screening being a good case in point. Also, the influence of direct-to-consumer advertising on volume growth. Examples being diabetes supplies or inhalation medications or Procrit which I see on my television at least once a day. There's no question in my mind that that drives volume.

I guess the final comment I'd make is that for some of these procedures it would really be interesting to see whether they're having the same increase in volume in Medicare+Choice plans. I understand that those data might not be easy to get, but the imaging centers for my managed care plan are running night and day, 24 hours a day, and it's a capitated plan. I wonder if some of the large Medicare+Choice plans have been tracking some of these procedures and could give some information with respect to volume growth where presumably the financial incentives should be more neutral.

DR. STOWERS: Kevin, just another observation, not

wanting to delve too deep into the E&M but looking back at what we were talking about before lunch, emergency room visits are increasing at three times the average of other E&M services. We're talking about shifting to the emergency room and that kind of thing. And new office visits are at half the rate of the average visits, meaning patients are either happy where they are so they're not shifting around a lot between physicians or there is an access thing there.

So I think it might be interesting to get into that E&M thing just a little bit, and it would sure be nice to have a little more -- as usual on a lot of things -- more recent data on where this ER visit thing is going. Because one thing that occurs on every ER visit is that E&M service, so it's almost an exact one-to-one relationship to the number of visits, which you said, or someone said earlier, might be kind of difficult data to get. But I think the fact that ii's increasing multifold over the number of E&M visits might be an indicator of where the patients are going.

DR. REISCHAUER: This is all interesting and the question is, what are we to make of it? The real issue here is whether Medicare's payment policies, or its lack of

management, is leading to excessive increase in utilization. We're not going to be able to answer that question but we can walk around the elephant and poke at it in various places.

I think the most fruitful way to do this is, as you suggest, look at geographic variation and see if there is a relationship between the growth of volume and the level of volume, and then what volume looks like in some places like Minneapolis, Portland, Salt Lake City where we're pretty sure people are going to say this is above-average care for America, and is there a lot of volume growth there or not?

The other thing to do is to try and look at what's happening in volume growth and levels for the non-Medicare population, the 60 to 65 people covered by Aetna, or something like that, and see if they're experiencing the same kind of increases in volume. If they are, then you can forget about the payment policy or the lack of management or whatever and maybe relax and say maybe there's a good thing.

DR. HAYES: We'll have some limited ability to do that. As you heard at the September meeting, we're getting a pile of private sector claims data from different payers.

We haven't looked at the data enough yet to say whether we can do something like looking at the near-elderly population and contrasting their use rates with Medicare beneficiaries, but it's possible. So that's just an option on that project, is to try and do that.

MR. HACKBARTH:

Depending on the private plan, the incentive that the individual physician faces may or may not be much different from what they face in Medicare. If they're basically in a discounted fee-for-service arrangement, it's really not any different. Now if you saw the same patterns of growth in a salaried physician practice or one that's fully capitated, then that might be particularly noteworthy, although be definition then the data are more difficult to get, and selection problems also potentially.

DR. ROWE: But there are some areas of the country and there are some states where capitation, delegated models, et cetera, are much more prevalent than in others. You might be able to get some proxies for that. Right, Allen?

MR. FEEZOR: Yes.

MS. DePARLE: I just wanted to follow up on Joe's

question which I think Bob has now followed up on well on where does this lead us in looking at the appropriateness of the volume increase? So I guess I would just ask Kevin, you and Joan, whether or not you have any other ideas of things we could look at to help us get some view as to the appropriateness of the volume increases other than geographic disparities that might exist.

DR. HAYES: You know that that's the toughest thing to try and deal with on a project like this, and the geographic variation is one hook we can use. It may boil down to exactly what Joe said, which is that we just need to have some updating of that earlier RAND work that was done in the late '80s. That was path-breaking work but it hasn't been updated since then.

I noticed in that IOM report on the quality chasm that they're still citing that as key research on the subject and nothing newer.

MR. HACKBARTH: From a policy standpoint, where we are today is we have a mechanism, the SGR mechanism, that sets a threshold if you will, and volume growth above that target is in essence presumed to be a problem, and we cut fees to offset the excess. So we don't delve into detailed

assessments of appropriateness and what the underlying reason for it are. This is a budget control mechanism and just is automatic.

This look at the issue suggests to me that even if you stay at that rather gross level that we're not trying to assess the appropriateness, maybe we would have taken a better mechanism if we tried to target the fee adjustments to the places that are growing as opposed to uniformly cutting the physician fees for all types of physicians providing all types of services in all parts of the country. If we could look at and say, there's particular growth here, there, or someplace else. That just might be another way into the problem.

I know that's a bit simplistic and I'm not suggesting that that's the right answer, but just a different way of looking at the policy problem than what we currently have.

DR. REISCHAUER: It might be just as wrong in the sense that you're targeting your bad shot rather than scattering it across everybody. Because something might be growing because it's amazingly appropriate now, and there's been new advances and all that, so we want everybody to have

three MRIs a day and that's the road to hell.

MR. HACKBARTH:

But the other response is to say, okay, that's right and what we should not do is have an automatic trigger mechanism as we do with the SGR. This inevitably requires judgment and what this data analysis does is focus our attempt to exercise judgment, establish appropriate clinical guidelines and standards. For my money, that's a far better way to go than automatic trigger mechanisms of any type.

DR. NEWHOUSE: I agree with that. I'd also like to observe the notion that if Medicare cuts its price and we observe a volume increase, or we don't observe a volume increase but we're worried that physicians may be ordering more to keep their incomes up, there's no reason in principle why, if they're doing that, they would limit it to that particular procedure, and there's no reason in principle why they would limit it to the Medicare population. Obviously, if it's a procedure that's only done in the Medicare population then the last point is irrelevant.

But I think the notion of getting out what the response is is particularly difficult for those reasons.

DR. ROWE: I think most physicians don't have a whole variety of procedures they do though. They just do one. So let's imagine a gastroenterologist who used to spend one day a week doing colonoscopies and the other four days a week teaching, seeing patients in the office, doing consultations in the hospital, et cetera, keeping up with the literature, and now finds that the amount that he or she can make in a day of colonoscopies is, instead of 40 percent of their income is now 20 percent of their income. So now they're going to do colonoscopies two days a week. And their threshold for doing colonoscopy may change. They just have to do this in order to compensate for the change. That's what I had a mind. So it would be just for one procedure per physician.

DR. NEWHOUSE:

The question is how often that's the scenario. Obviously there are colonoscopies among the under-65 too.

DR. ROWE: Unfortunately, I'm aware of that.

[Laughter.]

DR. NEWHOUSE: I am, too. I thought about saying, commenting from experience.

DR. STOWERS: Joe I just is want to make a comment

too. We keep saying it and I saw it in the reading that I ordered the MRI so I can make more money or increase my income. I don't get anything out of that MRI. I don't read it. I don't make any money off of it. I think we need to that make clear, that the incentives may be either I think the patient needs it, or professional liabilities with head injuries now that we do every head injuries, that kind of thing. But I think that most -- I would say the vast majority of tests that we order we make nothing out of. Yet we infer that we're ordering more so much, or the physicians are, because it increases their income. I'm not doing it to increase the radiologist's income that's going to read it. And it's a pretty rare situation that the person ordering the MRI really has a financial vested interest in that machine. Although there are cases where that occurs, I think that's the very, very vast minority.

So I think we need to really take a look at this incentive thing of where these orders are coming from for all of these tests. I think we've got the emphasis totally backwards on that in the way that the chapter reads and where the incentives are and that sort of thing. If I refer for a surgery or another colonoscopy or whatever, I don't

make -- it's not a financial incentive that drives all of that. I just wanted to make that clear. I don't know of -- very, very few physicians that send for an MRI that make anything off of it.

DR. ROWE: The question is how many radiologists send the patient back and say, no, you don't need the MRI.

DR. NELSON: I think either you or Bob made the point that the sustainable growth rate isn't intended to control volume. It's intended to control budget. I really agree with that. Expenditure targets and SGRs play absolutely no role in the clinical interaction or the selection of treatment. I've just don't think that the average physician has any idea what the sustainable growth rate is. They know at the end of the year whether the conversion factor goes up or down. But day in and day out in the practice of medicine they're oblivious to it.

DR. WOLTER: I would say, on the other hand, if it would be possible to monitor utilization in procedures that are done in a physician's office, in an ASC, in an outpatient hospital setting it might be interesting to see what trends emerge, especially given the report we're going to see later this afternoon. That would be very interesting

detail to keep an eye on.

MR. HACKBARTH:

Any hypotheses about it?

DR. WOLTER: Yes.

MR. HACKBARTH:

But none that you're willing to share. That's OK. Any other comments on this?

MR. DURENBERGER:

I hate to this, but the two things I remember from RBRVS -- and it was Rockefeller and I that did it despite the AMA was, one, the difficulty of getting Waxman and Stark in the same room at the same time on the last day of the session in order to do this. The second one though was with regard to expenditure targets and the volume performance standards. My issue then was, suppose all of the Minneapolis or St. Paul radiologists say, no, go on back, you don't need it, but when it comes time to impose the restraint they get hit with the same restraint as everybody else.

At that time, I think it was Gail Wilensky or whoever it was, said we'll try to get some kind of a regional or market distinction but it's relatively

impossible to do it.

So I guess the comment is, for those of us who have been around this issue from that point in time, and if you raise the usual issue of what should the right payment policy be, one of the issues I have in the back of my head really is the degree to which the combination of expenditure targets, volume performance standards and whatever the current law is, does it do anything at all to provide the kind of incentives to send them back without a scan or whatever the case -- whatever some other analogy might be?

The second is -- and I know people have time pressures and all that sort of thing, but if you would take one of these focus groups of yours and come to a community like ours, which is allegedly -- everybody says is the conservative practice, and actually have a focus group with folks and find out what's really going on there in this particular arena, because of the nature of the competition that exists between hospitals and the subspecialty, both in the diagnostic and the procedural areas, I think you'd find some interesting things.

I don't know what it would tell you in response to what's going on here, but it might give you some clues as to

how much of it is payment, how much of it is some other larger areas that relate to either health plan competition, or hospital competition, or the subspecialties.

My little hometown of St. Cloud, Minnesota, which for those of you who are Prairie Home Companion fans is Lake Woebegone, is probably now up to 100,000 people, something like that, but until a few months ago it had four MRIs in one square block owned by three different entities. And the fifth one just showed up in the last month or so because the orthopedic surgeons didn't want to deal with one of the other four so they put in their own. It's just an illustration of -- I mean, I'm not a researcher. I'm not even a very good analyst, but when you live in the real world as Nick is maybe suggesting, there might be some clues to us in going to a real community and focusing on some of these kinds of issues in that kind of a way to clue us in on where to spend our time.

MR. HACKBARTH: Jack and Alice, could you say a bit about what your respective organizations do in this situation? If you were in the same situation as the Medicare program and you were concerned about volume and intensity of service how to folks approach --

MS. ROSENBLATT:

I heard Joe say price, and the comment I can make is in California, which is where we have our largest population, we have a fee schedule that is sort of like RBRVS but not really like RBRVS. I remember making a presentation -- this is our PPO fee schedule. I made a presentation about three years ago to a physician relations committee giving all the very good reasons why it was different and they were was saying, RBRVS is great. You've got to get to RBRVS, and it was primarily because we were lower on some of the primary care stuff.

Did the same type of presentation this year and it was like, you don't need to go to RBRVS. That's quite all right. So just replicates the point made earlier, the physicians don't know anything about SGR. It's the level of the fees, and they understand that fees are going down.

Let me get to the question you asked, what do we do. I'd say we do two things, and I do think it's through price. We're trying to do more to understand the impact of our price, and the substitution of services. We've seen, for example, within our E&M codes, in certain areas there are different codes for a 10-minute office visit and a 20-

minute office visit, and the upcoding that we've seen over time is really interesting.

We also look at physicians versus each other in a group. We've got a computer program, some software that lets us do some comparisons. Wherever possible we're trying to compare a physician to similar specialists so we can look at outliers. But that's about it right now in the current state of things as is.

DR. REISCHAUER:

When you look at the outlier what do you do? You just don't sit around the office and say, hey, at outlier.

MS. ROSENBLATT:

Generally it gets into some sort of coaching going to that physician.

DR. ROWE: You write them a letter.

MS. ROSENBLATT:

Our experience has been that the physicians we deal with are very interested in seeing data. So if we can present data to them, that's a good thing.

DR. ROWE: I would agree with what Alice said. Let me give you one experience we've had of an initiative that we've tried to develop. In general, as we look at our

medical cost inflation we see that volume is more important than unit price. So that in general it's increases in volume are about two-thirds of the inflation and unit price increases maybe one-third. That's very, of course, in different sectors. Pharmacy by itself would have its own equation, and outpatient its own equation, et cetera. But in general it's volume, for physician services, over unit cost.

The answer to this, though it's unpalatable of course and may have some policy weaknesses, is obviously capitation. What we have done is to try to capitate some of the specialists in the areas in which the volume is the greatest. The area that we've had the greatest success with respect to this is in imaging. We have contracts now in dozens of markets about the United States with groups of radiologists where they are captitated.

So what happens is, if Dr. Rowe sends a patient for an MRI of their knee, instead of -- when I was practicing medicine and I had a patient who I thought needed an operation, I didn't order the operation. I requested a surgical consultation and the surgeon came and decided whether or not he thought or she thought the patient needed

an operation, and if so, which operation. I was an internist and I wasn't in the business of ordering operations.

So if you use that logic, Dr. Rowe orders an MRI of the knee. In the capitated situation, the radiologist sees the patient, examines the patient, says, you don't need an MRI of your knee. You can get by with a CAT scan of your knee for this diagnosis, or in fact a plain film of your knee. In fact since the radiologist is captitated and it's not the HMO telling the patient or the doctor that they can't do a test, we're not asking for precertification. We've having the specialist get involved before the MRI is done, which instead of just reading and saying -- applying their clinical judgment and saying, is this an appropriate application of the resources?

Now if the referring doctor feels that I really wanted that MRI, they'll get a call saying, we don't think the patient needs an MRI, we're going to do just a plain x-ray of the knee. Most of the time the doctor says, fine, whatever you think is the right thing. If he says, no, I really want the MRI, they do the MRI. And if they're dissatisfied with the way this radiologist takes care of

their patients they'll send patients to another radiologist. So it's in the best interest of the radiologist to use good clinical judgment and communicate.

We find that this approach is very effective. Now I don't know the relevance of that to the Medicare program but your question was, what are we doing to try to find some kind of hedge against this utilization increase and that's one approach that we've had over the last two years or so.

DR. STOWERS: I had a question of Kevin. Kevin, when we have this rapid growth in imaging and radiology and when we go back to talk about the SGR, is the total cost of either that or a major cardiovascular surgery credited back to the physicians or just the physician cost of that, the E&M service or the reading charge on the MRI? I'm just curious. It's not clear in here.

If the total charge is charged back to the physician, is it just the E&M service to read it?

DR. HAYES: No. First, we're clear that the SGR applies to all physician services, so any physician service, be it the EM service or the radiology service, whatever it is, all of that gets built into the actual spending that's subject to a target.

MR. MULLER: Not the facility piece. You're asking about the facility piece. That's not in there.

DR. STOWERS: It's just the doctor's charges.

MR. MULLER: The radiologist's charge in the example.

DR. STOWERS: I just wanted to clarify that.

DR. HAYES: The one exception to that is if the MRI is performed in a physician's office, payment is made under the physician fee schedule. So that spending is subject to the target.

DR. STOWERS: What about all of the blooming new outpatient physician-owned MRI radiology centers?

DR. HAYES: Those are subject to the target.

DR. STOWERS: So those are all dumping into the target.

DR. HAYES: Yes.

MR. MULLER: Are you sure of that, Kevin?

MS. BURKE: Actually, Ray, in the next paper when we talk about ambulatory surgical services there's a whole discussion about how in some cases it's wrapped into a single rate and the doc gets is if it's within a physician-owned, and then in other cases it's split out --

MR. MULLER: But there's no way a physician office visit is going to absorb a $1,000 facility fee. So the reason they spin these office facilities is in fact to get it out of the office, and having it bundled there. That's the reason for putting it out there.

MS. BURKE: You'll see some of that here, Ray, in that next discussion.

DR. MILLER: I just want to make a couple comments by pulling some of these things together. Joe, I just wanted to be sure on your comment, you're referring to the Chassen research?

DR. NEWHOUSE: Yes.

DR. MILLER: I wanted to be sure on that.

Also to your comment, Nancy-Ann, I think geographic variation is certainly one of the things that we have to look at and I think will be one of the most richest in trying to bring some additional light to this. But if we can chase some of this down, and depending upon how we can aggregate and parse the data, there are couple of ideas that were floated around here. Comparing it to managed care. If we could aggregate to areas that have high degree of penetration, there may be ways to proxy that if we can't

really drill down, right down to the beneficiary, that kind of level.

The notion of age and looking at it by age I think is a good idea. And if there's specific procedures that we know either have some kind of technological advance occurring or some payment change, they may represent opportunities where we can look almost on a case study type of basis.

In terms of policy I think implicitly what we're all talking about are different mechanisms, whether it's price, capitation, disease management, education, whatever it is, it's just is there a point at which the burden of proof shifts between the program and the provider? Which is not to say they don't get the service, but is there some point where the program begins to say, wait a minute, this is happening so far out of the norm, whether it's through education or some other mechanism, that the burden of proof begins to have to get called into question.

I think that's implicitly what we're talking about, as opposed to where to the burden of proof currently lies which is that the program pays under any circumstance.

DR. ROWE: It just happened in California with

those cardiac surgeons.

MR. MULLER: But that's so far over the standard deviation, according to the papers. If it requires that much of going over the standard deviation before you get dinged, it's difficult to run a program that way.

But I want to go back when we were talking earlier about the policy implications of this and the discussion we were having earlier today about how much you bundle and so forth. Part of what I heard in Jack's recitation of what one does is try to, at best, try to combine professional judgment with some kind of budget consciousness in a way that causes people to both make the appropriate clinical judgment, not do it just on financial grounds -- you know, defer when the person asks, I really want the MRI in his example. But not be an automatic pass-through for every request that comes.

Certainly capitation and the experience that we've had in the last 10 years was probably the closest to that. Medicare did in fact have capitation experiences. Obviously with the decline M+C it's been less. But one of the things we may want to be looking at, therefore, are there way of subcapping and bundling, even the absence of M+C if that's

not going to go over much. There still can be opportunities to subcap on certain services where, one, there is an explosion in technology that as Bob and others feel may be a good explosion of technology, but we want to make sure, especially if it's expensive technology, that there be some constraints on it that allow professional judgment to be exercised.

The reason I asked about imaging earlier is that there has been major technological breakthrough in imaging in the last five, six, years. The prices have gone down considerably so that they can, in Dave's example, be put on each street corner with good results. I mean, there are good MRI machines for $250,000 whereas 10 years ago they cost $2 million. So in fact that allows that kind of diffusion to go on.

So I think thinking through where the explosion of technology is most rampant and are there ways in which clinical and financial judgments can be put into more of a bundle I think is a fruitful place for us to look. Because I would not be surprised if we would continue to have technological advance in the next 10 years as we've had in the last 10 that accelerates very quickly. The

miniaturization is going to keep coming along in surgery as well. So one could certainly anticipate in the next, 10, 15 years in this program that far less invasive surgery will continue to explode. I mean, it will accelerate considerably, and therefore we will have big questions of how much certain procedures are going up because they're so much easier and less invasive to do.

Going back to Jack's point earlier, there's a lot of things one can do on 70, 75-year-olds that one wouldn't do on an 85-year-old, and 10 years ago you wouldn't even have touched the 70-year-old. So if in fact if it becomes far less invasive and the comorbidities are -- where the comorbidity for an operation would have been such 10 years ago that the cost benefit ratio would indicate don't do it, now probably that cost benefit ratio goes another way and my guess is it will get up to the 80-year-olds pretty soon.

So I see it, for example, on a surgical front and that's where I think, in addition to imaging, one will see a real explosion because there's so much biotechnical innovation going on. So therefore having some way of thinking -- if we can't go back to complete capitation, and

I don't think anybody around this table thinks we're going back to that any time soon, then thinking of subcaps and ways in which professional and financial judgments can be more tightly bound would be a good thing for us to keep evaluating.

MR. HACKBARTH: It's time for us to move on to the next topic, so thanks, Joan and Kevin.

Next up is issues in payment for ambulatory surgery services.

MR. WINTER: Good afternoon. This is the first year that MedPAC will be recommending an update to payment rates for ambulatory surgical centers. We'll be discussing the update issue next month. Today I'll be providing background on ambulatory surgical centers and how they are paid. I will also present data on the growth in the number ASCs, the volume of procedures they perform, and finally Medicare payments for ASC procedures. Finally, I'll address whether the ASC physician system has encouraged excessive growth in ASC services, and whether the system should be modified.

ASCs are separate facilities that provide only ambulatory surgical procedures and not other services.

Medicare has covered certain surgical procedures provided in ASCs since 1982. ASCs were seen as a way to move some surgical procedures from the inpatient setting to the less expensive ambulatory setting.

In 2001, there were over 3,000 ASCs participating in Medicare. These facilities provided almost three million procedures and received about $1.6 billion in payments. Most ASCs are for-profit and freestanding as opposed to hospital operated, and are located in urban areas. They are geographically concentrated. Sixty percent are located in 10 states 40 percent in the four states indicated on the slide.

Procedures that are performed in inpatient settings that can also be safely performed in ambulatory settings are eligible for Medicare coverage in an ASC. Procedures that are clinically inappropriate for an ambulatory setting, such as those that result in extensive blood loss, are excluded from coverage. Procedures that are performed in physician offices at least 50 percent of the time are also excluded from ASC coverage. This was intended to prevent migration of procedures from physician offices to higher paid ASCs.

This table lists the give highest volume procedures performed in ASCs for Medicare beneficiaries in 2001. Each category listed here consists of several related HCPC codes that are grouped together. Cataract removal, lens insertion accounts for almost one-third of the volume but halve of Medicare payments. Since 1997, this procedure has declined as a share of all ASC procedures. Colonoscopy and upper GI endoscopy, which together account for 28 percent, have been increasing as a share of ASC procedures.

The last category, minor procedures, musculoskeletal, includes interventional pain management services, which have also been growing as a share of ASC procedures. These services were discussed in detail in a Commission report last year.

Medicare uses a fee schedule to pay for the facility cost of services provided in ASCs. These costs include nursing and recovery care, anesthetics, supplies, rent and equipment. As with procedures provided in other settings, the related physician services are paid separately under the physician fee schedule.

The ASC fee schedule divides procedures into eight payment groups based on similar costs. The FY 2003 payment

rates range from $333 to $1,399. CMS is required to revise the rates every five years based on a survey of ASCs costs and charges. Between surveys the rates are updated annually using the consumer price index for all urban consumers. Because all payment groups are updated by the same factor, the relative values of the payment groups do not change. As explained on the next slide, the current rates are based on data from a 1986 cost survey.

In 1998, CMS proposed a new payment system for ASCs which would have been similar to the outpatient prospective payment system as it was proposed in 1998. The proposed system classified surgical procedures into 105 ambulatory payment categories based on clinical and cost characteristics. These APCs were similar to the outpatient APCs proposed in 1988. The payment rates were based on data from a 1994 cost survey that was based on a sample of 300 ASCs.

CMS also proposed covering new procedures in ASCs based on revised criteria. For example, procedures performed more than 50 percent in physician offices would no longer be automatically excluded from coverage. The revised payment system is classified for, among other things, using

outdated and inadequate cost data. The Benefits Improvement and Protection Act of 2000 required CMS to delay implementing this new system until 2002 and to base payment rates on cost survey data from 1999 or later.

The status of the new system was discussed in a recent letter from CMS to Pete Stark. The letter said that the cost survey required to revise the payment rates had not yet been conducted. However, CMS stated that it intended to expand the list of covered procedures in early 2003.

This chart shows that both the number of ASCs and the volume of procedures they perform have been increasing. The purple line indicates the number of Medicare certified ASCs, which grew from almost 2,300 facilities in 1996 to almost 3,400 facilities in 2001. That's an increase of almost 50 percent. Between 1991 and 2001, the number of ASCs more than doubled. The yellow bars show the number of procedures which have increased by over 60 percent from 1997 to 2001.

This chart shows the growth in Medicare payments to ASCs from 1991 to 2001 in both nominal and 1991 dollars. In nominal terms, Medicare payments doubled between 1996 and 2001. By comparison, Medicare payments to physicians

increased by about 25 percent and payments to outpatient departments grew by 17 percent over this same period. Growth in the number of ASCs, the volume of procedures they perform, and related Medicare payments accelerated between 1999 and 2001.

The rapid growth we have seen in ASC services raises some important questions. Is the ASC payment system encouraging excess growth? Should the payment system be modified? And if so, how? Finally, what ambulatory surgical setting provides the most value in terms of cost and quality to Medicare and its beneficiaries?

We'll first look at the evidence that the payment system encourages excess growth. We do not have recent cost data that would tell us if payments exceed costs. However, there is indirect evidence that they do. First, because the current payment rates are based on cost data from 1986 and have been updated since then using only the CPI, they may longer be aligned with costs. Changes in technology and productivity since then may have affected cost of procedures in ways that are not captured by growth in the CPI.

Second, the 1998 proposed rates which would not implemented were based on more recent cost data from 1994.

These rates would have lowered payments for high volume procedures such as cataract removal and GI endoscopies. This suggests that at least some payments in 1998 exceeded costs.

Third, some high-volume surgical procedures receive higher payments when performed in ASCs than in outpatient departments or physician offices. This may create financial incentives to shift procedures from other ambulatory settings to ASCs.

This table compares the facility fee for ASCs and outpatient departments for the five highest volume surgical procedures performed in ASCs. With the exception of cataract removal, the ASC payment is higher than the outpatient hospital payment for these procedures. These payment differences may reflect underlying variations in cost between settings. However, it is unlikely that ASCs cost more than outpatient departments, because hospitals incur expenses that ASCs do not, such as the cost of complying with EMTALA. If payment differences are due to factors other than variations in cost, there could be financial incentives to move services from a lower-paid to higher-paid setting.

This table shows that several ambulatory surgical procedures have been shifting to ASCs from other ambulatory settings. The aggregated categories shown here include most of the procedures on the previous slide. The share of these procedures performed in ASCs grew between 2.5 and five percentage points from 1997 to 2000. Although MedPAC has previously expressed its concern that payment variations could drive shifts in setting, it is important to acknowledge other factors that may also play a role in the case of ASCs.

For example, changes in medical technology and practice patterns in areas such as cataract removal have influenced the growth of ambulatory surgical procedures. In addition, ASCs may offer beneficiaries greater convenience than outpatient departments and for lower coinsurance.

Another possible factor is that there's more control over the scheduling of patients than outpatient departments, which allows them to perform more procedures. In addition, physicians can increase revenues by investing in ASCs.

Next we'll turn our attention to whether the payment system could be modified to minimize financial

incentives to shift services between settings.

The ASC payment system should be based on four main principles which would apply to any payment system. Number one, the payment for services should be aligned with their costs.

Next, as the Commission has previously stated, payment differences between settings should not inappropriately influence the site of care. These two principles are linked. If the payment for service in a particular setting is lower than its cost there is a financial incentive to shift the service to a setting in which the payment equals or exceeds the cost, assuming that such a setting is available.

Third, product bundles should ideally be broad enough to offer providers opportunities to improve efficiency. In other words, the product should include a broad set of inputs that allows providers to economize resources. For example, by using fewer lower cost inputs.

A fourth principle is that the payment system should be administratively feasible. For example, CMS should be able to collect the data to implement it without causing undue burdens on providers or the agency's own

resources.

This slide compares two potential models for restructuring the ASC payment system based on three of these principles: aligning payments with costs, ensuring financial neutrality between settings, administrative feasibility. I have not shown the product bundling criterion because the ASC product, the surgical procedure, is already fairly broad. It includes the facility services related to the episode of care. That is, the surgical preparation, the procedure itself, and post-op recovery.

The first payment model shown here is to set a separate payment rate for each procedure code, similar to the physician fee schedule. The second model is to set payment rates for groups of procedures with common costs and clinical characteristics, similar to the outpatient PPS. The first model would align payments with cost for each procedure code, while the second model would match payments with costs for groups of procedures.

The first model would reduce incentives to move services between ASCs and physician offices because the payment systems would be more comparable while the second model would improve comparability of the ASC and outpatient

payments and thus reduce incentives to shift services between those two settings. This assumes that procedure groups would be similar in each setting.

It is probably more important to ensure comparability between the ASC and outpatient settings than the ASC and office settings because most ambulatory surgical procedures are provided in outpatient departments. The first model would be less administratively feasible than the second because CMS would have to set rates for each of the 2,300 procedures covered in an ASC. For the second model, CMS would set rates for a smaller number of payment groups. In addition, it would be easier to incorporate low-volume procedures into payment groups using their clinical characteristics.

If the ASC payment system is to be based on the outpatient PPS, there are several issues that need to be considered. The first issue would be whether to use the same ambulatory payment classifications and relative weights used in the outpatient PPS. Using the same APCs and relative weights in both settings would improve the consistency of the two payment systems. It would also be simpler to maintain one set of APCs and weights rather than

two.

Another issue would be whether to use the same adjustments in each system for geographic differences in labor prices and changes in input prices. In order to make decisions about how to structure the payment system and at what level to set the rates, it would best to have updated data on the cost and volume of ASC procedures.

There are two options for collecting updated cost data. The first is for CMS to conduct a new survey of ASC costs and charge, which it is required to do every five years but has not done since 1994. As mentioned earlier, CMS has said that a new survey has not yet been conducted and we are unaware that any action is imminent.

The second option is to require that ASCs submit cost reports, which would provide more complete cost data than a survey. Until updated cost data become available in interim step could be to use the current outpatient PPS rates as a reference point for setting ASC rates. For example, the ASC rate could be based on the outpatient rate minus an adjustment factor. This would probably require legislative change because BIPA requires CMS to use cost data from 1999 or later when revising the payment system.

Because ambulatory surgical procedures can be provided in multiple settings with varying payment rates, it is important to ask what setting provides the most value in terms of cost and quality. Should Medicare pay more for a procedure in one setting versus another even if the costs are higher?

An example of this issue is the shift of some ambulatory surgical procedures from the physician office setting to ASCs where the payment is higher. It is unclear whether the higher cost of an ASC is matched by improved clinical outcomes. In order to address this issue more research needs to be done in at least two areas. One, is the same service delivered in two settings comparable? For example, is the patient mix similar?

Two, are there clinical reasons to prefer one setting to another for certain procedures or patients? For example, do clinical outcomes for high-risk procedures or high-risk patients vary from one setting to another?

This concludes the presentation. I would appreciate your feedback on the information presented here and the questions we've raised.

MS. DePARLE: Ariel, thanks for an interesting

presentation. I guess my question has to do with -- I think the research questions that you presented are interesting one, and I guess I would say that I think our time and resources would best spent on those questions, as difficult as they are, perhaps impossible but at least difficult as they are to answer, than launching into something about a new payment system at this point.

I was there, as I know you were there too at HHS when we proposed in '98 treating ASCs as we repeating, or similarly to the way we were going to be treating outpatient hospital departments. To try to move to some new payment system, it may be true that doing something that's closer to the outpatient PPS would be more administratively feasible, but I want everyone to understand that the feasibility of this is -- this will be a very difficult project given the lack of data. I don't think we can really suggest that we're going to move toward requiring them to do cost reports. That's not exactly going in the direction we're most -- I think people are these days.

Bottom-line, we just decided we had too many other problems trying to move forward with the big issue which was the outpatient department prospective payment system. This

one, at least then the number I remember was we were spending around $1 billion a year in this. Is it still around that level?

MR. WINTER: In 2001, it was about $1.6 billion, so it's gone up since then.

MS. DePARLE: It's not trivial, but it's not what we were dealing with another areas. I just want to make sure everyone understands what a massive project it would be for CMS to undertake this. So I'm not sure what the urgency is, if you're asking for our reactions to whether we think this is a good place to spend time. But I think the research questions are really interesting and that would be making a contribution if we could come to some understanding about the quality delivered in the different settings.

DR. ROWE: Ariel, just a couple of points. I think a comprehensive discussion of this area might also include a little more material on the differences in the patient populations between inpatient or hospital outpatient and ASC. It's not just a random migration of some part of the hospital-based population to these ASCs. These are healthier people in general, younger people in general, et cetera. To whatever extent costs are not taking into

account the more nursing time that might be required with the sicker, frailer, older population, more physician time, additional anesthesia resources, et cetera, that's one thing.

Second is, and my experience one of the reasons physicians like this is that there's no training going on. There are no students. There are no residents so it becomes very efficient. That's very good, of course, and Medicare is not paying GME I guess here, and therefore it's really less expensive for Medicare from that point of view. But that might be put in there as well.

My largest concern relates to -- and those aren't concerns. Page three there's a statement that says, to account for geographic differences in market input prices, the labor portion of the rate is adjusted using the hospital wage index for the ASCs location. In my experience, depending upon how far away it is from the hospital campus and the proportion of ownership that is the hospital -- as long as the hospital owns less than 51 percent which is usually the case because there's usually an outside for-profit investor, and physicians own some part of this -- that ASCs are not bound by union contracts and most ASCs are

non-unionized.

That is in fact the reason many hospitals do this. If they have a union contract and they're in a strong labor environment they can in fact build one of these, if it's far enough away from the campus and they don't own 51 percent of it, and they don't have to have organized workers, in which case the pay scale might be different, and in which case the application of the local geographical hospital wage index would be inappropriate and might have Medicare overpaying for those activities.

So I would assess that because I think that might be a significant issue.

DR. REISCHAUER:

Just the comment on Jack's last point. This is a relative adjustment so if there were perfect correlation between union and non-union wages across areas it wouldn't make any difference. The level doesn't make a difference, it's the relatives that may -- I mean, if all the non-unionized workers made 80 percent of the unionized workers then applying the wage index wouldn't bias things. But that's a separate issue.

I was looking at this and I didn't know whether to

have my blood boil -- we'll duke it out outside.

DR. ROWE: I just need to be instructed with respect. If the hospital wage --

DR. REISCHAUER: He said if you apply the hospital wage index to adjust for labor cost differences across areas it wouldn't necessarily be right.

DR. NEWHOUSE: I'm saying, suppose Columbia Presbyterian builds one of these in Westchester County, does it get the New York wage index either way?

DR. REISCHAUER:

I'm not sure why that makes any difference.

DR. ROWE: If New York City is heavily unionized, and without commenting that's a good thing or a bad thing, it's just heavily unionized and that influences the hospital wage index for that area, but the workers in one of these places that are not-unionized --

DR. REISCHAUER:

But what I'm saying is, if the non-unionized workers in New York and in Omaha --

DR. ROWE: Have the same relative --

DR. REISCHAUER: -- each received 85 percent or 80 percent of the unionized workers, then applying the index

across -- we would be overpaying maybe everybody but it wouldn't be --

MR. HACKBARTH: The implicit premise there, Bob, is that unionization is just as prevalent in Omaha for hospital workers as it is in New York City and that may not be the case.

DR. REISCHAUER:

I'm sorry I brought it up.

DR. ROWE: I think your general point is well taken, which is that my point isn't as interesting as it seemed like it may have been.

[Laughter.]

DR. ROWE: But I'm not sure I accept your premise about the --

DR. REISCHAUER: I was trying to be polite.

DR. NEWHOUSE: Bob, I think what you need is that you need the mix of union and non-union in the ASC to be equal to what it is in the hospital, because you're applying the hospital index to the ASC, and that's what Jack is saying, because it's not.

DR. ROWE: What's your second point?

MR. HACKBARTH: Yes, let's move on to the next

area.

DR. REISCHAUER: We could move to our union representative here to make the judgment.

I read this and listened to your presentation, both of which I thought were very good and I didn't know whether to have my blood boiling or else to think, is this really a problem? Because I'm looking at the data here and it shows that 29 percent of the procedures and 50 percent of the cost have to do with cataract surgery, and an ASC is paid 40 percent less than an outpatient hospital setting. So in a sense, Medicare is saving big bucks there but it's paying more in the others. Then if you do, I think what was behind Nancy-Ann's thing, it might be that it's coming out not a whole lot different.

Then you read and you say, we're basing this all on 1986 costs or whatever is, why go through all these alternatives about new procedures? Why doesn't CMS just do what it was asked to do in 1998, now that it's finished with its heavy lifting? It just strikes me as strange that they haven't gone forward and done that. I don't know if you know why they haven't. It sounds like there's some political pressures, I'm sure, not to do it.

MS. DePARLE: It isn't that easy to do it. That kind of a survey has to be approved by OIRA, the Office of Information and Regulatory Affairs. When I was there we tried to do one for physicians and we could never get it approved. It's not an easy procedure to do, but I don't know the answer about -- I mean, the law does require them to do it. I don't know what the answer is. Ariel probably knows.

MR. WINTER: I'm sorry, I don't. I'm sorry to disappoint you.

DR. REISCHAUER:

Before you answer let me just say that I come down where Nancy-Ann does, which is that we shouldn't spend a lot of time on alternative payment mechanisms, and looking more thoroughly at these questions I think is the most interesting area to go in. I for one would like to have us go through further in this, whether Medicare should pay more for a procedure in different settings even if costs are higher issue, because I know that's not our -- I mean, our policy is yes, but I think the right answer is no.

MR. HACKBARTH:

So are you saying, Bob -- I didn't catch the last

part. Are you saying that you think we should have some discussion of the principle?

DR. REISCHAUER:

Yes, of that principle.

MR. HACKBARTH: That struck me also, Ariel, on page 12 of the presentation, the principles for redesigning the ASC payment system, the first one being payment for services should be aligned with costs. I'm not sure we would have 100 percent agreement on that. An obvious alternative is that for a comparable service we ought to pay at the rate of the most efficient provider of that service, whatever the setting is.

Now that begs the question about whether in fact they're treating comparable patients in the different settings, et cetera. I know from personal experience that those are legitimate, real issues, but I'm not sure that everybody would line up behind this first principle as stated on page 12.

MR. MULLER: The data on page 11 of the text that we were handed shows that the labor costs in hospitals is 60 percent and ASCs is 35, and that's clearly not random. When we go to the principle that costs should be -- that we

should go with the lowest cost provider, they're obviously way beyond EMTALA. A lot of regulations on hospitals.

Let me give you an example, since I've built ambulatory surgery centers in addition to hospital outpatient units. Just simple things like sprinkler systems, the walls, the recirculation of air. There's a lot of overhead that the hospital is required to do by state regulatory code in every state that doubles or triples the cost of the building right there. Same thing with staffing, the whole 24/7 and so forth. So it's not just the payment mix.

I'll bet you that most of these ambulatory surgery centers do not do a lot of Medicaid. Hospitals are required to take Medicaid and so forth. So there's a lot of reasons. The cost one is fairly profound because it's not just the building itself because most outpatient departments these days have to be built to inpatient code, and one of the reasons you build ASCs is you can build them like a strip mall and then just stick a little operating room in the middle under much lesser code, and it's two to three times. You take your chances. That's why you do a cataract there rather than something serious. And the staff requirements

are --

So I think to say that just to take the lowest cost setting and that just becomes the basis for that, especially when it's regulatory requirements that caused these other settings to have much higher cost is something we should take into account, especially if the regulatory requirements come from the same government that's paying the cost.

I wanted to answer the narrow question and then I'll come back on my other points later.

MR. HACKBARTH:

I don't dispute any of what you're saying. I've actually spent a lot of time hearing that from folks at the Brigham in negotiating these rates. I think all of that is true. Let's stipulate that. It still begs the question though of whether it's the appropriate public policy to treat patients in higher-cost facilities when lower-cost facilities are available offering equal or better quality.

Now there are all sorts of issues about, are we going to under mine the financial base of big hospitals and all that. My point was not to answer what the right guiding principle should be, but to say, I don't think that I could

just raise my hand and say, I agree with the first bullet here as the appropriate guiding principle for Medicare. It is a lot more complicated than that.

DR. NEWHOUSE:

Three comments on the align with cost issue. First of all, particularly for the hospital outpatient department the cost we typically tend to look at our accounting costs, meaning that quite a bit of overhead has been allocated there and the cost is therefore somewhat arbitrary artifact. That presumably applies much less to the ASCs since they're freestanding entities. So I don't think cost comparisons are going to be very straightforward to do.

The second comment you made, Glenn, in your last remark which is really about Bob's remark that maybe it wasn't such a bad thing because it was mostly cataracts and Medicare saved money as it shifted out of the outpatient. My reaction was, was that just going to lead the hospitals to come in and ask for a larger update factor because margins have gone down? But that level on generality, we're not going to see it, I don't think.

The third thing is, let's postulate that the

clinical acuity in the hospital patients is more severe. So you put somebody in the outpatient department because you want some standby capacity nearby. Therefore you say, these are more severe patients and they justify a higher cost in the hospital outpatient department than in the ASC. So you start to pay more in the hospital outpatient. That's presumably for the same reason we want things to be neutral, could affect patient flows in an undesirable direction.

So it's not clear to me there's any very easy answer here, which may lead me back to Nancy-Ann's position, although it's probably not what the Congress is looking to us for.

MR. DeBUSK: This is sort of, Ariel, an academic question. As these less invasive procedures are established or are developed by manufacturers of a product or what have you, that are being done in the acute care setting, do they almost immediately move to the ASC after they're developed because the cost?

MR. WINTER: I don't know if I can answer that question right now. I think with cataract removal, lens insertion that was done initially in the inpatient setting and then eventually migrated to the ambulatory setting as

that became technologically possible. That's true for some other procedures too that are done in ASCs like arthroscopic surgeries. But I'd have to go back and look and see at what rate that happens and for what procedures that's happened.

MR. DeBUSK: Apparently something is in play there because there's a lot of development now in that area from the manufacturer's standpoint. Seems like -- I'm just looking at it a mile high, but it looks like that all ends up in that ASC, and I assume it's because of cost.

MR. WINTER: Keep in mind too that not all procedures that can be done in an outpatient or inpatient hospital setting are approved for coverage in an ASC. ASCs are not allowed to do procedures that involve major blood vessels or could involve major blood loss, so that excludes a lot of cardiac procedures that are done in outpatient departments.

MR. DeBUSK: Second question. When there's a new, less invasive procedure and they're now doing it in the ASC setting, who sets that rate for that ASC for that procedure? That's set locally by the --

MR. WINTER: The rate is set nationally by CMS, or was set nationally based on '86 data, and that's updated

annually based on the CPI. So it depends on what the initial cost was. That determines the payment group that the procedure falls in. Then that's adjusted for local labor prices.

MR. DeBUSK: But if it's a new procedure, if it's a new way of doing a procedure that was in the hospital, someone is going to set a new rate. They're not going to automatically pay that hospital rate, are they?

MR. WINTER: I see what you're saying. The first question is about coverage, and CMS is required to update the list of covered procedures every two years. However, it has not done so since '95 with the exception updates for coding changes. They proposed to expand the list of procedures in '98. That was not finalized although Tom Scully has indicated in a letter to the Hill that he expects that to be finalized in 2003. So that would include a whole new list of procedures that were not previously covered in ASCs. Then the rates would be based on, I assume what -- I'd actually have to think about that some more. I'm not sure how they would set the rates for the new procedures. It would be based on the existing categories but I'm not sure how they would decide which category it goes into, how

they determine the cost of those procedures.

MR. DeBUSK: It would be interesting.

MS. BURKE: Ariel, I just had a question about this strange geographic trends that we see here, particularly one that suggests significant centralization in four states. Three of them you can look at and see population trends, but Maryland sticks out there as kind of an odd one. And other ones that you might have imagined, Massachusetts, Pennsylvania, other states where there are large concentrations. I just wondered what we knew about, why those particular states? What is it about them that would have led to the exponential growth in the number of facilities?

MR. WINTER: That's on my list of things to do and I haven't gotten there yet. But I do have on my list of things to do to call someone in the Maryland health department who deals with ASCs and talk to her about, what's unique about Maryland's environment that's encouraged a lot of these facilities to open.

MS. BURKE: I'm as interested in why they haven't grown in other states where there are large concentrations of elderly.

DR. ROWE: I can tell you about New York because Carol and I used to be on the committee that reviewed these, kind of a CON-like process. We called a moratorium because we weren't clear that there needed to be so many.

MS. RAPHAEL: And there were issues in rural areas where in one area where there was only one rural hospital in quite a large radius there was a physician group that wanted to set up an am-surg center and pull the most profitable cases out of that one rural hospital. The state would have also required that hospital to provide the backup service for that particular ambulatory surgery center, and it just became a big political, controversial issue.

MS. BURKE: I can certainly imaging, and I suspect, Ariel, as you look at this there are clear issues between urban and rural, and proximity to sole community providers. There's a whole series of issues around that. But there are huge pockets of large concentrations in urban areas that you don't see here. Again it's just trying to understand what the pattern is and why. Whether it was, in fact decisions made at a state level in terms of physician groups who either wanted to didn't, or the hospital association essentially argued about it.

DR. ROWE: I guess my point was that New York had a regulatory apparatus with respect to these and many states don't.

MS. BURKE: That's what I'm saying. It may in part be a regulatory issue in terms of the states, but it just seemed an odd map.

MR. WINTER: That's good point. Most states do have certificate of need requirements for ASCs and that's probably a factor in what determines the states in which they've grown -- in which they choose to locate.

DR. ROWE: One of the other factors, Carol remembers these meetings were very raucous, is that oftentimes the largest community hospital was sponsored by the Catholic church and the ambulatory surgery center was planning on doing interruptions of pregnancies so there were those kinds of issues.

MR. DURENBERGER:

I was going to ask Sheila's question but she asked it and I appreciate that. I, number one, endorse your comments relative to the first principle. I think my comment refers to the second principle and it gets to the issue of who actually makes the decision about where to go

for things like cataract, colonoscopy, upper GI and things like that. I just don't see -- I would like to see some kind of a principle oriented the choice that the patient makes and I think it gets at it on number two in some way.

There is something to be said for access, satisfaction, and convenience, and some of those factors but I'm not sure I know exactly how to state a different principle.

MR. SMITH: Sheila asked my question and Joe made most of my points, so very quickly. I can't think of any product that I wouldn't love to have the '86 fully inflation adjusted price for.

DR. REISCHAUER:

If you were selling it.

MR. SMITH: If I were selling it, right. Nancy-Ann may well be right as to whether this flame is worth the candle, but clearly this is a circumstance where costs and prices are way out of whack, and if we can do something about it, we should.

Just to second though what Carol and Jack were just talking about. This is a service which probably undermines, clearly has a staff mix which is cheaper, partly

because of regulatory requirements, perhaps because of unions, although I think Bob's response to Jack is right: as long as the ratio is constant it really doesn't matter.

But this is a different service in part because it's being performed in a place subject to a different set of requirements, regulatory requirements as well as staffing requirements. To think that the way out of this is to apply simply the cost of the lowest efficient provider seems to me to miss the point. Maybe the way out is to focus at least the next round of effort on Nancy-Ann's first question, is this the same service but have a somewhat more expansive notion of what the service is than we usually apply.

MS. RAPHAEL: I just want to, in line with that, if you remember, for nursing homes we decided that the hospital-based nursing homes dealt with more complex cases and in fact had a different product than freestanding, and we justified an update for them. I don't know whether that's a parallel model.

MR. HACKBARTH:

I think it's almost certainly true that the patients are different. In fact I'm not sure that we can quantify that but anybody involved in decisions about where

patients go for these services knows the patients are different. In the case of our relationship with the Brigham, there with a very explicit decision about what type of patients ought to go to the hospital outpatient department and which ought to go to the freestanding facility based on clinical considerations.

So if we could somehow quantify what the differences are I guess we would be making a contribution. But I don't think it would be a great insight to say the patients are different. We could just stipulate that.

There still is, not withstanding the points that David and Ralph have made, all of which are legitimate, I think still some legitimate policy questions that you could debate about how we should set the price, whether it's the lowest efficient, or whether we need to take into account these burdens that are placed on some of the competitors and what-not. The fact of the matter is, we're going to see more of this, more things moving out of the hospital, different types unbundling of the hospital, and maybe it's worth therefore of trying to work through some of those issues. This is inevitably part of Medicare's future.

Bob, did you have a comment?

DR. REISCHAUER:

Yes, just on are the patients different? I would think that a very simple, very crude test would be average age. When I think of some of these things like colonoscopies or cataracts I'm wondering is it really that sensitive here? We could look also at the age distribution in California where these things dominate versus someplace where they don't and see whether there's a huge difference.

MS. ROSENBLATT:

I just want to make a comment here as a consumer because I had three very similar surgeries done, probably all coded the same thing, two in ambulatory surgery center in the Beverly Hills no less, and one in the outpatient department of a hospital. So the service, if you looked at how it was coded, I bet the procedure would look the same to a statistician. But in terms of what was done, the outpatient department -- I mean I was hooked up to more devices. It wasn't much safer feeling.

Now if I ever have to have it done again, it would be in the outpatient department, not in an ambulatory surgery center.

So I think we need to be very careful when we're

saying the same service should have the same cost. You really need to dig in, what does that same service mean, because it's coded the same but it's different.

MR. HACKBARTH:

Although I've talked to some patients that have had a similar experience and they would say, I never go to the hospital outpatient department if my doctor says it's okay to do the freestanding facility. It is so much more preferable as an experience.

DR. WOLTER: I guess I would just weigh in on the side of this being an extremely important. I've heard a number of comments about it's limited to certain parts of the country, but I'll tell it's in Kalispell, Montana, Helena, Missoula, Billings, Cody, Wyoming. And it's not just ASCs. It's imaging centers, it's freestanding hospitals that are focusing on single specialty surgeries. I think it is one of the major emerging trends going on right now. It's wreaking havoc in many communities.

I think there are significant questions about the conflict of interest it puts some physicians in in terms of their decisions about clinical service and if we take a bye on it this year we'll be back at it in 12 months almost

certainly. I would say we should be looking at this very, very serious in terms of how it will affect American health care.

The last thing I'll say, there's many things to cover on this issue. Unit pricing is one issue, but the tremendous capital investment that's going into all this is a whole other issue, and is that kind of public policy that we would like to support with maybe not addressing the issue?

MR. FEEZOR: It's a larger issue of what's doing to the medical centers in terms of the outflow of these products and services.

MR. HACKBARTH: We need to move on. Jack, go ahead and then I want to pose a question.

DR. ROWE: Just I want to add one thing to Bob's list. I think the patients are different, as we talked about earlier, and age is a good proxy. But also Medicare has some other data that I think would be very helpful in just utilization, cost of Medicare services used by the individual in a given year is a pretty good proxy for how sick they are, whether they've been in the hospital, et cetera, and Medicare would have that data.

So if you looked at age and then if you looked at quintiles of expenditure, I think that would be a nice proxy for out sick they were.

MR. HACKBARTH:

Let's resolve what we're going to do on this front. Actually we are not required by Congress to say anything about ASCs. There's no report here, no requirement that we make a recommendation about the update. That was something that we chose to do; is that right?

MR. WINTER: That's correct. I'd like to just remind the Commission that you did make a recommendation regarding ASCs in last year's report on interventional pain management services in which you recommended that the Secretary evaluate ASC rates based on more recent cost and charge data and update the list of covered procedures.

MR. HACKBARTH:

So as I see it we've got a few options. One would be simply to make an update recommendation and perhaps make David Smith's observation that given that these are based on 1986 costs inflated by the consumer prices they are almost certainly too high. We don't think any update is appropriate. That's just my personal opinion.

DR. REISCHAUER: I'll cover you as you back out of the room.

[Laughter.]

MR. HACKBARTH: For the record, that's my opinion, not the Commission's.

So one possibility would be just to address the update issue and only the update.

A second would be an update recommendation plus a recommendation for the revision of the system. Personally, I am persuaded by what Nancy-Ann had to say about the complexity of that task, and given the relatively small amount of money currently in these services. I'm not sure that would be a good course, but we could do that.

The third option would be to make a recommendation about the update and either in the March report or in the June report, somewhere delve into the philosophical questions that pertain to ASCs and other services being pulled out of the hospital, which should be our guiding principles about payment rates.

Then the fourth option, of course, is just to be totally silent ASCs. Would do you think? What are your preferences so we can guide the staff?

MR. FEEZOR: I supported Nick's raising of the larger issue. I wonder though if that one doesn't take a little more time and serious thinking and might be one that I would suggest we put into the parking lot for maybe the July offsite, that we give a little more serious thought.

MR. HACKBARTH:

Certainly I don't think we'd want to tackle that before the June report. My thinking is we'd ask the staff to think about it and come back with a recommendation. Is that something we want to try to tackle for June or in the longer term?

DR. NEWHOUSE: My problem with that is that for much of this there's a big non-Medicare market. So it's not clear to what degree we're driving the trends that we're seeing. Cataracts is largely out of the hospital now anyway.

MR. HACKBARTH:

So does that mean, Joe, that you don't think --

DR. NEWHOUSE: I'm happy to talk about it at the offsite.

MR. HACKBARTH:

So, Joe, you're not convinced that we can --

DR. NEWHOUSE: I'm not convinced -- I mean, I'd have to talk about it that off-site. I'm not convinced that we can meaningfully contribute to the congressional debate over what to do in Medicare payment by trying to take on the issue of the entire system. There it seems to me the state regulation point that Jack and Carol were making probably has a role to play rather than Medicare payment policy.

MR. HACKBARTH:

What about on the update? Do you think we ought to make a recommendation there?

DR. NEWHOUSE:

From what I've heard it's not clear to me that we can get to a sensible -- have sensible data on a recommendation unless we want to say we think that growth has been so rapid that we infer that payment adequate. That's just sort of a corollary of David Smith's argument.

DR. REISCHAUER: I think when you see the growth in both procedures and the numbers of ASCs you know something good is going on from the investor's standpoint here. Since this is our first shot at making a recommendation I think it would be a mistake to be silent. Even if we don't say we know anything, I think we should

talk about it just to stake out the turf and let people know that in the future we're going to. But I feel comfortable, based on the little knowledge we have, that we can say something.

MR. DURENBERGER:

Let me to say, I think for several off us that the something relates back to the volume that we just finished, physician volume as well as this, as well as perhaps the technology coverage and reimbursement issues. So I'd just -- saying something in the larger context or what you refer to as the philosophical context as opposed the update? I think that's what Nick has been -- I think he made that observation.

MR. HACKBARTH:

What I heard Bob saying was, say something about the update, albeit it based on very limited information and then we can talk about whether we can say something about the broader philosophical policy, but we're not sure if we can contribute to that conversation right now.

DR. REISCHAUER: But I think the issues that Nick raised and the complications pointed out by Joe are really worthy of some serious attention, like a year from now's

June report. We could do something very interesting that would spread to imaging centers and another kinds of facilities.

MS. BURKE: I think there is the broader question which I do think we should engage over a longer period of time about what the implications are for hospitals and the pulling out of services one by one.

But specifically with respect to the update and reimbursement, I think there is a question short of that which is, what is our view about determining whether or not the services and the patients are the same and whether there ought to be equity irrespective of the point of delivery? That I think is short of the broader question of what are we doing in terms of the broad context of what's a hospital tomorrow and what should it be.

But do we, or should we at this point also suggest that that is a question that at some point must be engaged, which is there's a question of something good must be going on because there's a whole lot of people doing it. But it's also a question of, are we going to examine whether these are patients similarly positioned to patients that are being served at other sites, and is there an enormous variance in

those payments that makes sense?

I think we have to at least suggest that that's a question that ought to be asked because they may be different patients. My guess is that they are in number of circumstances, but my guess is there are still a whole lot of cataract patients and is it because of comorbidities or a variety of other things that keeps them in a hospital outpatient department as compared to something else, so should they be paid higher? And then what about all these other things?

So I think we have to signal that in some fashion, even if we don't have the data that allows us today to know what the differences are and whether the payments are in excess of what's reasonable in one case and understated in the other case? Because I don't think we know but I think we have to signal that is a question that should be engaged, at least driven our general principle about the payment shouldn't drive where you go.

DR. STOWERS: I agree with everything that's been said but I think as long as we're being philosophical about it, we're going to talk about this in the long run, the real underlying problem is that our hospitals are surviving on

cost shifting and are not adequately being reimbursed for the private pay patient and for the Medicaid and so forth. Therefore, they have to rely on that.

I think these ambulatory surgical centers are just making us face that. So as they're stepping away and not having the burden of taking those other patients, but the problem is the overall reimbursement system is messed up. Because of that cost shifting, what roles are the ambulatory surgical centers forcing us to think about that, and what role are they going to play in the long run in this?

So I think we really have to step clear back to that level as we take on this problem, because I agree with whoever said it, this kind of thing is going to happen more and more and more.

MR. MULLER: I support the suggestion made by someone earlier that we look at this in the next year, starting in July and make that a big theme as we have to evaluate them in '03, '04 as to -- and I also think ambulatory surgery explosion, imaging explosion, the technology explosion, a lot of the themes we discussed today are highly interrelated, so I think we should try to figure out how to weave those together.

A brief factual point on why some things are still in the outpatient area. Not all parts of the country has ASCs so you can't go to one. So even if there was one around every street corner then in fact one could surmise that they would move out. But one of the reasons that not everything has moved out to an ASC, like cataracts and so forth, is there's not and ASC everywhere. As Ariel has pointed out in the presentation list, there's still a fairly limited number of procedures that can in fact be done in ASCs.

I would suspect that if the payment incentives stay as they are right now there will be enormous pressure to increase the numbers of things that are done in those settings and that accelerating explosion that Nick referred to by having towns in Wyoming and Montana have it would be seen more and more around the country.

I also want to go back to one of my earlier points. The regulatory requirements are quite significantly different, and since Medicare requires that these hospitals, outpatient departments comply with these state codes, in a sense we are complicit in that it's not just an independent choice that they've made. For us to say, you must comply

with local codes, but then we're going to pay you as if you you're in a strip mall is unfair.

DR. NEWHOUSE:

I just want to throw out one implication of pursuing the line, are the patients different, and let's postulate that they are. Then that implies that the ideal payment system with in fact adjust for those patient characteristics. Then we have, as Nancy-Ann says, risk adjustment which we have some experience with.

MR. SMITH: Most of what I want to say has been said so I just want to touch -- I would not want to pursue the difference question limited to patient characteristics. It seems to me that we ought to go at this in July in the fuller context that Nick and others have raised, and not simply say, these are different patients.

MR. HACKBARTH:

So the plan is that we will comment on the update, acknowledging that we have only limited data. I think we can do that quickly in the March report, and then perhaps foreshadow that we thing much bigger issues lurk in the background or have some interest in pursuing them later on.

MR. WINTER: Then we're taking out any

recommendations related to revising the current payment system, right?

MR. HACKBARTH: Yes.

MR. WINTER: Just focusing on the update.

MR. HACKBARTH: What I hear is there's agreement that given the amount spent, Nancy-Ann's points are well taken and we ought not recommend a revision, full revision of the system right now.

Thank you.

Next up is another easy area, Medicare coverage decisions.

MS. RAY: Good afternoon. At the September meeting you expressed interest about how coverage decisions are made in Medicare so I'm here today to give you a very brief summary of how that is done as well as a sample of the issues that we discovered when we reviewed a literature concerning about how Medicare makes coverage decisions as well as our discussions with several policymakers and provider groups.

Four principal ways coverage decisions are made in Medicare. National coverage decisions are made by CMS. Local medical review policies are made by Medicare's

contractors. Payment and coding guidelines published in manuals and CMS's program memos are implicit coverage decisions some say. And contractors can also make case-by-case interpretations. I'm going to describe each of these processes and in doing so try to highlight similarities and differences between them.

National covers decisions are developed by CMS and they apply nationwide. The national coverage decision process is usually reserved for major significant medical advances of an item or service. The NCD process can be initiated when CMS receives a formal an outside group. CMS coverage staff can also initiate the process under a number of different circumstances including if they find inconsistent local coverage policies exist, or the service represents a significant medical advance and no similar service is currently covered by Medicare, or the service is the subject of substantial controversy, or there is potential for rapid diffusion or overuse.

Over the last several years the national coverage decision process has become a more open, evidence-based and transparent process. For example, CMS refers most national decision requests to outside impartial groups to supplement

the agency's scientific and medical expertise. One group, the Medicare Coverage Advisory Committee was chartered by the Secretary in 1998 to supplement the agency's clinical expertise. It consists of six medical specialty panels and an executive committee. They recommend to CMS whether an item or service meets the criteria for coverage by Medicare. Now I want to note, however, that the MCAC is advisory and all final decisions are made by CMS.

CMS can also opt to have an outside technology assessment performed by an impartial group and Agency for Healthcare Research and Quality are one of those groups that they can refer technology assessments to.

I also want to make a note as a part of the open process that the MCAC meetings are held in public and CMS's web site does provide transcripts of the meeting as well as the national coverage decisions that are made by CMS.

Local medical review policies, by contrast, are made by Medicare's contractors. I guess I'd just like to spend a little bit of time discussing how the character of LMRPs differ somewhat from national coverage decisions. I guess as the story is told, LMRPs originated from contractors performing utilization review. LMRPs are

administrative and educational tools to assist providers in submitting correct claims for payment. So there's really a multiple function of LMRPs. Not only do they give instruction about coverage but also about payment, coding, and documentation as well as an educational context of LMRPs.

In contrast to national coverage decisions the majority of explicit coverage decisions made by Medicare are made by contractors through the LMRP process. As opposed to national coverage decisions that apply nationwide, an LMRP applies in the area served by the contractor only. LMRPs are often made to address high cost, high volume services. They also can be made about concerns arising about beneficiary access or program safeguards. LMRPs cannot conflict with a national coverage decision. They can, however, supplement a national coverage decision.

Finally, CMS does encourage contractors that operate in two or more states to develop uniform policies to the extent possible. Now similar to the national coverage decision process, the LMRP process is becoming more open and public and evidence based. Since 2000, CMS is requiring contractors to make decisions in an open and public process.

Specifically, contractors have to allow for the submission of information from the general public, and contractors also have to provide for open meetings for the purpose of discussion draft LMRPs. There is also an LMRP web site that is available.

Just to give the example of what carriers are required to do, they are required to establish a carrier advisory committee in each state that's composed the physicians, and to provide a forum for exchange between carriers and physicians. The CACs are composed of physicians, a beneficiary representative, and a representative from other medical organizations. They're required to meet three times annually.

Carriers are also required to hold public meetings after posting a draft LMRP, and then once the public meeting take place then they go ahead and present the draft LMRP to the CAC.

I just want to note here that each carrier and fiscal intermediary can make his or her own LMRPs the medical director. By contrast, the four DMERCs are required by Medicare to develop and use one set of coverage policies for coverage of durable medical equipment services.

There are several other ways coverage decisions are made in Medicare. Interpreted manuals and program memos are sometimes somewhat de facto coverage decisions and they do apply nationwide.

For example, in the dialysis world Medicare pays for up to three hemodialysis sessions per week. This is actually in -- it's not in the statute. It's in one of CMS's manuals. So this is a de facto coverage decision some say. The fourth dialysis session however can be approved on a case-by-case basis, and it's a determination by the fiscal intermediary contractor.

Now it's important to note at this point that for the most part services do not go through an explicit coverage process. One reason for this is the way Medicare pays for many services through a prospective payment. In that case, providers are the purchasers and can use the mix of services needed, how they feel that they will efficiently be able to furnish high-quality canner.

Another factor important to note is that most advances are generally incremental. As long as there is an existing code and payment for a service closely related to the incremental advice then the new advance doesn't usually

go through the explicit coverage process.

At this point I'd like to discuss some of the issues raised by our review of this topic. This is not meant to be a comprehensive list of issues but just several that came to staff's attention. The first issue has to do with what evidence is considered when of developing coverage decisions. At this point Medicare does not explicitly consider the value of an item or service when making its national or local coverage determinations.

By contrast, many private payers and purchasers do consider information about the value of medical services when making their coverage payment decisions. In addition to that, the Department of Defense and the veterans program also does consider value.

In addition also, many manufacturers of drug, devices and biologics often sponsor studies evaluating the value of their service. These studies are often published in the peer review literature. Participants of MedPAC's expert panel on paying for new technology generally agreed that Medicare should consider evidence on the value of a service when making payment and coverage decisions.

Now this is not a new issue for Medicare. In 1998

CMS set forth a four-step process for considering the value of a service when making coverage decisions. It was not adopted, partly because of resistance by certain groups and manufacturers who contended that CMS did not have the statutory authority to deny coverage because of issues related to value.

I'd like to move on at this point. The second issue is a multifaceted issue and it focuses on how decisions are made up both on the national level and on the local level.

One of the issues that came to our attention is the fact that local coverage policies vary from area to area, and even with an area when you have an FI, a fiscal intermediary, and a carrier making different coverage decisions about the same service. There has been a lot of debate and there has been a lot of discussion about the advantages and disadvantages of this variation. I'd just very briefly like to touch upon a little bit about the discussion that we have heard from folks.

I think the biggest concerns raised by everybody that we've talked to is that -- the concern is to what extent does the local variation versus uniform national

policies affect beneficiaries access to high-quality care.

On the one hand, we heard the equity and efficiency argument that local variation impinges on beneficiaries' access to care, and that Medicare's coverage policies should equally apply to all beneficiaries. There's also the efficiency argument; that's not efficient for 50 entities, the FIs and the carriers, to each be making decisions about a service.

Moreover, patients don't understand why policies vary from rom area to area. There's the provider burden for physicians who are in more than one contractor region as well as nationally-based providers, chain facilities, who are affected by contractors' local medical review policies and they have varying expectations about documentation, coding, and payment policies.

On the other side of the argument, some contend that local variation provides -- that the LMRP process provides the Medicare program flexibility. There are a lot of different reasons why we need flexibility. Flexibility is needed because of differences in state laws, licensure, and scope of practice differences, and that we need flexibility in dealing with coding issues and documentation

issues.

There is also, on the LMRP level, the educational aspect and the benefit of the medical director meeting with physicians and the medical director being able to address program integrity issues. I guess the group supporting LMRPs would also suggest that there's many opportunities for local input into the process.

Finally, the local process could improve access to care because medical services are permitted to bubble up through the local process thereby actually beneficiaries having quicker access to innovative services while permitting opportunities for providers and manufacturers of the service to build a body of evidence necessary to seek broader coverage.

Another aspect of how national local coverage decisions are made is with respect to the resources that are devoted by both CMS and the contractors. Our expert panel on new technology raised concerns about CMS's resources. Unlike Medicare, certain private payers, the VA, and the military health care system conduct studies to compare the+ effectiveness older services against newer services. In addition, many private and public payers actively monitor

the development of new services in the pipeline.

Providers and researchers have raised concerns that Medicare's contractors have different technical capabilities to conduct assessments of the available scientific evidence when making local coverage decisions. Some important research is currently being done by folks from the University of Minnesota regarding that issue and concerns have been raised about differences in the capability, capacity, and resources devoted by the medical directors of the carriers and the FIs.

Finally, certain provider groups have raised concerns with contractor's expertise about specific clinical conditions. For example, at open door meeting on ESRD policies several providers noted that the proficiency with ESRD clinical issues varies among the FI medical directors.

The last issue I'd like to talk about is increasing the coordination between CMS and the Food and Drug Administration. Many policymakers contend that a closer collaboration between the two agencies could result in CMS making more timely coverage decisions. This issue was recently at the June meeting of the Secretary's advisory committee on regulatory reform. They recommended in their

September meeting that the Secretary should issue a memorandum of understanding between the FDA and CMS that defines the process the two agencies will employ to permit the exchange of information and to support collaboration relative to their respective review of innovative and medical device technologies while maintaining the confidentiality of trade secrets and another proprietary data.

There have been concerns raised about this collaboration, and as noted in the recommendation one of them is the issue of confidentiality of manufacturer's data. Other issues raised by individuals have been the blurring and diluting of the FDA process, and potential delays in the FDA process.

That concludes my presentation at this point. Like I said, we've tried to raise at least some of the issues that the raised by researchers and policymakers concerning how Medicare makes coverage decisions. I'd like at this point to hear from commissioners whether or not you're interested in staff exploring these issues in greater detail. Thanks.

MR. HACKBARTH:

Before I open it up for comments let me just spend a minute trying to frame the question that I'd like your reaction to. In our March report we will have material related to how Medicare pays for technology in both the inpatient and outpatient settings that we've discussed at previous meetings. In the course of those discussions one or more commissioners asked for some educational material about the coverage process, which is what Nancy has just provided us today, at least at a higher level. To this point we had not planned on going beyond the payment issues to the coverage questions.

The three issues raised here are each in their own right big issues, complicated issue, and certainly with regard to the first two, very sensitive issues that would require a lot of careful thought and work to handle well. As you'll recall, a lot of people reacted negatively to our recommendations in the regulatory burden report of December a year ago where they thought we were away too simplistic, to quote at least one person, in terms of our consideration of the local versus national coverage issues.

For me it is a reason though, if we do it, we'd want to do it in a careful, thoughtful way and not just dash

into it and try to put together something quickly that may not be appropriate for the task.

Just to kick off the discussion, for my money I think that coverage issues regarding technology are very important issues for the program, going back to our discussion earlier about what's driving the increasing cost. I think this is one of the significant factors, and if we're serious about wanting to get a grip on costs we need to take a look at these processes.

Having said that, I don't have any brief or any particular outcome, just a general concern about the issues raised. So what I would like to do it is say, yes, we will delve into them but we will not try to do it in a very hasty way. I don't know whether that means trying to do something for June or the next cycle. We'd have to get the staff to think some about that and provide a recommendation to us.

Reactions?

DR. NELSON: I was one of those that tried to separate in my mind the payment issues from the coverage issues and not confuse the two in our considerations, and I found this very useful. I would favor having some reference to the current way that coverage decisions are made, either

as appended to or part of the report or freestanding, even in a brief way, because I think there's such a confused audience out there that doesn't understand.

I have no idea what percentage of the MCAC recommendations, for example, are adopted. I know they work hard, they come up with 300. Whether that takes or not is something that I don't know about. But there's enormous confusion about the role of the local coverage review process as compared with the national coverage review process. I think it would be helpful for us to try and clarify and eliminate some of that confusion.

Now with respect to busting our pick on these broader issues, I tend to favor not doing that on a hurry-up basis. I think we could have a simple descriptive analysis of the current process that wouldn't take a half-dozen pages and still be useful. And then biting into this other stuff at leisure.

MR. DURENBERGER: Mr. Chairman, I'd just add a recommendation -- I mean, I support your recommendation. While the issue is kind of an old issue -- I think it's been around for administrators for a long, long time and it's been challenging to deal with. It has lacked in the past

for a lot of good foundation, and there's still a lot of foundation I'm sure the needs to be laid under the way the decisions are made. But the relationship between coverage and payment, or between coverage and reimbursement will naturally lead you towards some kind of value-based decision which is where I think you're suggesting CMS should be going.

So I would strongly support your recommendation that we not hurry into it, but that we do go into it and we let people know that we are, and at some point in time we will have recommendations to make.

DR. WOLTER: I would just add, and I'd be interested to see if Nancy-Ann has any comments, but from the provider side we have, at times, had extreme frustration in this area. And it's not just about new technology. It has to do with existing services like air ambulance, cardiopulmonary rehab, rehab and therapy services. We have sensed a tremendous variation intermediary to intermediary in what gets covered. We've also not been able to negotiate the maze of getting the issue on the table and addressed in an efficient manner between local, regional, and national contacts.

So I think it's an important issue for beneficiaries who I think sometimes end up with inconsistent availability of various services. So I think it's an important area. The time frame, I would agree it should be done in a thoughtful manner.

DR. WAKEFIELD:

Based on what I've heard from some of the providers in my region of the country they certainly share exactly the frustration, Nick, that you have just mentioned especially when they're dealing with regional headquarters out of Denver and also out of Chicago, and they've got facilities across state borders and the necessity for being familiar with and complying with different expectations, it is a real maze and there's a lot of frustration that I hear at least at the local level for some of those, especially our larger providers who are doing business in a lot of different places.

The question that I have, Nancy, is is there a network for sharing some of the local -- when local medical review policies are made and they're based on some evidence is there a vehicle for sharing in a fairly efficient fashion those decisions across the country? And how rapidly might a

local decision being made in one area disseminate to another, especially if there's some good underlying evidence for a particular decision having been made?

I got the point about coverage contractors operating in two or more states being urged to develop uniform local coverage policies, but I was wondering beyond that, what's the vehicle for moving those local decisions, especially if there's some good evidence that underlies them more broadly? Is there any?

MS. RAY: I am aware that the medical directors do have clinical work groups. So for example, there is a clinical work group on ESRD. That's my understanding. So I think that is one mechanism for which information is shared. And of course, the LMRPs are posted on www.LMRP.org.

MS. DePARLE: I think there actually are legal restrictions though, Mary.

DR. WAKEFIELD:

In sharing?

MS. DePARLE: Not in sharing, but each carrier medical director has to go through the process using their own technical advisory committee, TAC I think they call them. That's the way the process is set up and they can't

just say, the person over in Iowa came up with something good and I think I should use it here. I believe there have been a number of lawsuits by physicians against, and maybe providers against them for doing things like that so they have to independently do it.

I'm not sure -- for the DMERCs there's a different, I think they have a different authority. But that's what I remember.

I made this statement before but I just want to underscore that I do think this is a really important area for the program. Not only for understanding costs and how spending trends may develop, but also for access and quality and outcomes for beneficiaries as well, Nick, and you, Mary, have made points about providers. I think that the paper that Nancy wrote, that some version of that is a public service in itself. There isn't readily available something that describes in five or six pages the process as well as the does.

In fact I thought it was better than -- we have also commissioned some papers from Project HOPE that we've seen and I thought this was very good at explaining in a simple way.

There was a point about it though that didn't seem correct to me and I just wanted to ask you about that.

On page five you talk about in 1998 CMS proposed a four-step process for considering the value of an item. And actually, to go to Glenn's point about he thought this was important but was not inclined to do a rush job on it. I think it's important for everyone here to remember that Medicare has been around now almost 40 years and still has not defined what is reasonable and necessary, and that's what all this goes to.

There have been, as Senator Durenberger pointed out, several efforts to do that. The first proposed reg in 1989 that tried to lay this out and tried to get into cost-effectiveness but really more cost substitution analysis, and then was not ever finalized. But the next effort I think was in -- in 1998 we did propose a Medicare coverage process. It was actually a proposal. We said, here's how we're going to make national coverage decisions.

But the Clinton administration's version of cost-effectiveness was never proposed in a rule-making. We did something, a very unusual administrative animal that I had never heard of before, but it was called a notice of intent.

The reason we did that, it was a relatively short document but we wanted to lay out for the industry, Congress, everyone in a formal way, what we were thinking about as a way of moving towards evidence-based decision-making and defining reasonable and necessary and coming up with some sort of cost-effectiveness.

Then we wanted to use that as a vehicle for working with everybody to see if we could finally develop something that would be capable of being enacted as a rule. And it was 2000 and there just wasn't enough time, so I don't think, unless something else happened in 1998 which I don't remember, which could very well be the case, I don't think that that occurred.

I wouldn't say wasn't adopted because of resistance. I think that was the case in 1989. I think the industry has moved a substantial distance toward understanding that the FDA's decision about something being safe and effective is not the same thing as saying that it's covered by an insurer. So I don't know that it's fair to say that that's why CMS did not finalize that rule. I think at least for my part I didn't go forward with doing a proposed rule we just ran out of time, and I'm not sure

where current administration is on it. So that's what I'd say about that.

Then finally, I want to also make the point, and you sort of made this but maybe it wasn't as clear in the document as it should be, that it's true when I came to the program I felt strongly that Medicare is a national program, people should get the same thing; that's how it should be. Certainly there were frustrations with on a daily basis Senator Durenberger's colleagues calling me and saying, why does so-and-so in Mississippi get this, and so-and-so in Arkansas get that, and a lot of that had to do with these local medical review policies that were made.

But I do think there is a solid basis as well for variation in policies and much of it has to do with that it may be difficult for a newer technology to amass the kind of evidence that it should have for a Medicare make a national coverage decision saying everyone should get this, or people in this situation should get it. Medicare's allowing local medical review policies allows new technologies, smaller companies that come up with something new to get coverage on a smaller basis and then amass the evidence that is necessary for Medicare and other insurers to make a decision

about whether it really adds value. So I would just say that.

MS. RAY: I just want to make one response. The issue about the resistance by the manufacturers, that was something actually that we found noted in a couple of policy documents and articles published about the whole process, but I hear your point.

DR. STOWERS: I just want to make a comment about what Nick said. It's not just new and upcoming technology. It's those 9,000 decisions that are sitting out there that have occurred in the last decade that are all over the place. Like I've said before, half of our situation was in one state under one carrier and one under the other. I wonder if there's not something to be learned from those previous distributions. I've seen things where the majority of it is maybe in 40 states and another one is uniform in 30 states, and another one is in -- but it's not in these five states. How can we say that the five states -- is there a certain percentage of coverage across the country that would warrant national coverage?

I think we need to start thinking that way a little bit because there may be some way -- if we somehow

knew that distribution of this 9,000 coverages, of a few key ones, I think it might be helpful for us to really see what's happening out there. But I don't think we know. I know what was happening with us, but if we could look into that a little more I think it would be helpful.

DR. REISCHAUER:

Just to build on Ray's point, do we know whether over time there is a regression toward some national policy on these? While I can understand Nancy-Ann's argument for locality, there's a lot more rational ways to do this. You could divide the country into four regions and have certain policies apply to one for a three-year-period, at which point they're reviewed and then decided up or down for the whole nation, rather than to have these 50 entities making these decisions.

Nancy, did you imply that the decision that's made by a carrier or an intermediary doesn't necessarily spread across all of their territory? I mean, that it's state specific? If you have something like United Wisconsin covers 20 percent of Part A and its Nevada, California, Wisconsin, Massachusetts, Georgia. It's like, what's going on here? But you say they can have different decisions in

each one?

MS. DePARLE: I think they can, and some of that has the do though with the history of Medicare and how nothing shall interfere with the practice of medicine. There's the first part of the Medicare law, so there's a lot of variation that the local carrier medical director doesn't -- the technical advisory committee to that carrier medical director is by state and they don't want to change their policies.

There may be areas, and she noted this, where there are policies that have to do with utilization where they say, you can only get two MRIs in a day, or two of some procedure. Why they do that? Because in a particular are, you wouldn't believe this, but people are trying to do that. You might need that in one area of the country and not need that kind of a policy in another area.

So I think there's something here about looking at those 9,000 things that are out there and whether there's some way to rationalize those and go ahead and declare some of them national policies and move forward from there. My point about variation was more in the diffusion of newer technologies, not this old stuff that we've been covering

for years.

MS. BURKE: Can I ask just one quick question? I actually never thought about this before. When a decision is made at a local area, one of the 9,000 decisions that's been made, if another area appeals the exact same issue is it automatic?

MS. RAY: I'm sorry I didn't hear you.

MS. BURKE: In terms of the multiplicity of local decisions that are made, is there any procedure at CMS when they are reviewing what has occurred at the local level that should a subsequent request for the exact same issue arise that you don't have to literally go through the same process but it is presumed to have been dealt with?

MS. DePARLE: They don't review it. They don't review what happens at a local level.

MS. BURKE: As we look at options, short of going to a full national review, one option might well be, to the extent that there are decisions made whether they can be presumed to have been made should subsequent requests come forward. I mean, case law essentially is what it is.

MS. DePARLE: It's only been in the last year or so that CMS in Baltimore has even had access to what the

local carriers are doing. Contractor reform is part of this.

MS. BURKE: One of the things we might want to think about, if they're a step short of going to a national coverage decision, that essentially maintains the local decision and the old concept of localities and individual physicians but still brings some order to that process.

MS. DePARLE: That would be a nice goal.

MS. BURKE: It might move us forward.

DR. WOLTER: Glenn, could I just make a quick comment on that, just to give you an example of what exists? We've had nearly 400 air ambulance transports downgraded from one payment level to another. There is no appeals process. You appeal each one as an individual claim through several levels and ultimately to an administrative law judge. And in over two years of working through this process there's not been a way to get it in front of a body that could try to compare it to other intermediaries or create some consistency.

I think that's really the issue, is how can we take these 9,000, if that's the number and have a more consistent approach.

MR. HACKBARTH:

Let me just ask for a quick show of hands. Based on those people who have spoken it sounds like there is interest in taking up the value and consistency questions in coverage. Let me just see a show of hands. All in favor of doing albeit --

DR. NEWHOUSE: What's the timeframe?

MR. HACKBARTH:

It would be a longer one, and exactly what long means will depend on some discussion with the staff about workload and what-not. But it certainly would not be for the March or even the June reports. I think we're talking about next cycle probably, right?

DR. MILLER: I think once we get down to this that will be the case. We can give you an assessment. Remember there's also this mid-round, just doing this informational piece on the coverage process.

MR. HACKBARTH:

I'm going to come back to that in just a second. On the big issues of value and coverage decisions and the consistency questions not only do we have the constraint of staff time, we've got the constraint of commissioner time.

Given what we need to do at the commissioner level for March and June already I'm not sure we can tackle new, big, complicated subjects.

So when it would be, I don't know, but it's unlikely to be in this cycle.

With that caveat, who would like to see us delve into these areas?

Okay, a clear majority in favor of doing that.

Now in the meantime, what we could do is take Nancy's paper and refer to it, add it as an appendix to the March report where we take up the related but different subjects of how you pay for technology once it is in the system, and at least do it there or be available for people interested in the material.

DR. NEWHOUSE: I like that idea. I thought if we did it it would probably be good if we could have a little fuller discussion of the private sector than was here, particularly the Blue Cross process I have in mind.

MR. HACKBARTH:

If you have some specific information that you think that Nancy ought to include what I'd suggest is that you folks talk and then as we start to go through the drafts

for the report we can get an updated version of this draft appendix as well that might be expanded to included that material.

DR. MILLER: We did have the information from the Project HOPE contractor analysis. Was that what -- I'm envisioning that for March this appendix might include both of these pieces of information.

MR. HACKBARTH:

Okay, I think we've got a plan.

Thank you, Nancy.

Next up is M+C payment areas. This again is the result of some previous discussion in the Commission. I can't even remember, Scott, when it was at this point. It was a while ago. But in one of our previous reports we raised some issues about use of counties as the payment areas for M+C plans and asked for some analysis of potential options. That's what Scott and Dan are here to present.

DR. ZABINSKI:

As Glenn just said, today we're going to discuss alternative definitions for payment areas in the Medicare+Choice program. The payment areas are basically the geographic basis for setting payment rates in the M+C

program.

Now the current definition of the M+C payment area is the county. Using the county as the payment area does raise some concerns. One concern is that there is large variation in per capita spending at the county level, and consequently in the payment rates amongst counties which raises an issue of equity in Medicare+Choice, because areas with high payment rates are more likely to have an M+C plan and a choice of plans. This problem is especially visible when neighboring counties have very different payment rates and people who live close to each other end up having different access to M+C plans and different benefit packages to choose from.

A second concern about counties is that they may not reflect market areas served by managed care plans because the county boundaries are drawn without any attention to matching market areas. This disconnect between payment and market areas can create inappropriate or undesirable financial incentives for M+C plans.

And a final concern over counties is that some have too few beneficiaries to produce accurate estimates of local per capita fee-for-service spending. This is

something pointed out in detail in the March 2001 report. This problem creates an obstacle to effective implementation of a MedPAC recommendation of financial neutrality between the M+C and fee-for-service sectors because financial neutrality requires equal payments in the two sectors after accounting for differences in risk.

In addition, there is greater year to year variation in per capita spending in small counties which means greater annual variation in payment rates in those counties, and consequently greater risk to the plans that serve them.

Now we have explored two alternative definitions of payment areas that would address at least some of the problems presented by counties. One alternative is what we call hospital labor markets which have been considered by many sources including the Commission. The idea would be to collect urban counties into metropolitan statistical areas and then rural counties in each state into a single rural area, and then set a payment rate for each collection of counties.

The other alternative is to cluster relatively small geographic units into payment areas for accurately

reflect market areas served by managed care plans.

For the remainder of this presentation we'll discuss the positive attributes and the problems presented by these two alternative. First we'll discuss the hospital labor market definition.

Now using hospital labor markets would have a couple of positive attributes in relation to counties. First, there would be less variation in per capita local fee-for-service spending and consequently less variation in payment rates among the 370 hospital labor markets than under the 3,100 counties. This smaller variation under hospital labor markets is reflected in the MedPAC finding in the March 2001 report that shows that the largest difference in payment rates between neighboring payment areas would be smaller under the hospital labor market definition than under the county definition of payment areas.

A second positive attribute is that we would have fewer problems with inaccurate estimates of per capita local spending because the smallest hospital labor market has about 3,500 beneficiaries which is more than nearly half of all the counties.

Now despite these positive attributes about

hospital labor markets there is a concern about them that they may be so large in some instances that they encompass heterogeneous market areas for managed care plans. Heterogenous markets in a single payment area can be a problem because there may be large differences in the cost of providing care within the same payment area. In such a scenario, plans would have an incentive to serve the low cost areas of a payment area and avoid the high cost areas.

Now by law the M+C plans are actually restricted in being able to respond to that incentive, but because of that restriction plans have to make a decision of whether or not to serve an entire payment area. Consequently, if Medicare started using hospital labor markets as a payment area, plans could face suddenly large losses in high cost markets that they currently serve under the county definition, and consequently may choose to withdraw from them or at least decrease benefits or increase premiums.

Now we performed a data analysis to determine whether hospital labor markets actually do encompass heterogeneous market areas and the results from that analysis do suggest that heterogeneity does exist at least to some extent. For example, we found substantial variation

in per capita spending in some hospital labor markets. In the Washington, D.C. MSA annual per capita spending is more than $3,500 or 80 percent higher, in the highest cost county than in the lowest cost county. Other MSAs such as Philadelphia, New York, and Boston also show similar variation.

In addition, the behavior of commercial HMOs provides more evidence that hospital labor markets encompass more than one market area in some cases. In some hospital labor markets, for example, different parts of the hospital labor market are served by different commercial HMOs.

Now I'd like to turn to the other alternative we explored, that being clustering small geographic units into Medicare+Choice payment areas. Now if this clustering is done properly, payment areas would actually like homogeneous market areas. This would eliminate the problem of hospital labor markets that I just discussed, that being payment areas are much larger than market area for managed care plans.

In addition, clustering would reduce or eliminate some of the problems presented by counties. This includes reducing the problem of payment areas that do not

approximate market areas, and the problem of payment areas and having too few beneficiaries to produce reliable estimates of local per capita spending.

Now there may be a large number of geographic units that could be clustered to develop into payment areas but we considered three possibilities that we believed would have some beneficial attributes. One possibility is to use the 3,200 hospital service areas as defined by John Wennberg and colleagues at Dartmouth Medical School. A one-sentence definition of those hospital service areas is that they are collections of zip codes that have a plurality of Medicare hospital discharges within the same city or town.

We think a positive attribute of these hospital service areas is that they are intended to reflect local hospital markets which may make them a good building block for developing payment areas to approximate market areas for manage care plans.

A second possibility for clustering is census tracts which were developed by the Census Bureau. Census tracts are intended to include populations that are homogeneous with respect to demographic characteristics, economic status, and living condition. We believe the

homogeneity in these variables would be useful because it could provide a solid basis for constructing payment areas that reflect homogeneous market areas.

A final possibility we considered is to use counties. Counties may not as good of a building block as our hospital service areas or census tract, but they do have a nice feature in that the data necessary for establishing payment areas are readily available at the county level. For example, the leading work on clustering small geographic units into Medicare+Choice payment areas use the county as the building block in part because of the ease in obtaining county-level data.

This research was performed by Hans Dot and a group of researchers at CMS who clustered New York counties into larger entities intended to reflect market areas for managed care plans.

Now a couple of slides ago I mentioned that clustering small geographic units into payment areas has a potential to eliminate or reduce at least some of the problems presented by counties and hospital labor markets. However, there is the downside to this concept because there are some large obstacles into putting it into practice. One

obstacle is that the final data such as service information may not be readily available for some geographic units. This would be a problem, for example, with using census tracts.

In addition, clustering appears to be very difficult to do effectively because it requires a firm set of rules to follow, but there is actually no clear set of rules that have been established. This difficulty caused by a lack of clear rules was encountered by Dot and his colleagues in their work that clustered New York counties into managed care market areas. Now because they did not have a clear set of criteria to follow their clustering method ended up using a lot of trial and error. This method turned out to be quite cumbersome so as a result they have only been able to develop market areas for New York State.

Now in a conversation with them they said they would like to develop them in all states, but they anticipate some difficult in doing that because method that they used in New York may not be appropriate in all states so they may have to start from scratch in some states.

Now ultimately I find the summary of these results somewhat discouraging, and I think the key point that given

the current options for defining payment areas you face a lot of problems. First of all, the payment areas that would be easy to implement, that being counties and hospital labor markets, have some serious shortcomings. At the same time, a solution that would address at least some of those shortcomings -- by that I mean the clustering small geographic units to reflect managed care market areas, appears to be very difficult to implement.

Now given these problems in defining effective payment areas on the staff we're pretty uncertain about whether pursuing the concept further would be fruitful. Now of course if the Commission feels that it would be worthwhile to do more work on this issue, we'd be glad to do that. Primarily the question we're asking is guidance on where we should go from here.

MR. HACKBARTH:

This issue is an old friend of mine. This has been an issue and a problem since the early 1980s or earlier. I think you've done an excellent job of summarizing the dilemma. The problems with the county unit are clear. The problem is there's no better alternative that we can implement.

Given that frustrating state of affairs, I'm not sure it's an area where MedPAC has a lot to contribute. Maybe someday a researcher will come up with a method for clustering smaller units into true health plan market areas, or maybe Alice has already come up with that.

MS. ROSENBLATT:

I was reading this and an idea came to me that the problem we're trying to solve I think is variation -- it's basically a problem of not enough people to generate what an actuary would call credible data. The other part is --

MR. HACKBARTH:

The problem is to get a desirable unit that has several attributes. One is it would be large enough to be stable and you wouldn't have this bouncing around from year-to-year.

MS. ROSENBLATT: But that's critical.

MR. HACKBARTH: That's the one you're talking about.

A second is that the units would be relatively homogeneous in terms of the composition.

And third, you would not have major border problems. You wouldn't have cliffs as you move from one

unit to the adjacent unit. So you're trying to optimize for those three attributes. The stability is probably the easiest of the problems to deal with. We can figure out ways to deal with that, but they will tend to aggravate the homogeneity and the cliff problems.

MS. ROSENBLATT: But anyway, let me just throw my idea out and then you can all say that's ridiculous. But if you say the county is the easiest thing to deal with and the county has all these different problems, then you raise the issue of, is there a way to do county in a better way?

One of the ideas that came to me is, when an actuary doe experience rating at the case level, depending on whether the case is small or large you apply a credibility factor, you adjust for large claims, and you use the actual experience of the case for the part you believe is credible. It's kind of like Joe's partial capitation idea. For the part that's not credible you have some metric that's called a manual rate.

So it's almost like what the BBA did in terms of the weighting between the national and the county-level factor. But another approach to it would be, instead of using a national factor for this manual rate component,

you would use what Medicare pays providers in that county for services. You would develops a theoretical PM/PM based on actual payment rates in that area. Like the physician fee schedule in California there are nine regions, so you'd account for which region it is.

So just another way of looking at it as opposed to fooling around with what is the location, but say, okay, let's assume the counties -- what we've got to deal with. Can we do a better job of coming up with a payment rate?

DR. NEWHOUSE:

Several comments. First, Alice, credibility is really not so much the issue within the metropolitan areas.

MS. ROSENBLATT:

The credibility would be 100 percent at some number of beneficiaries.

DR. NEWHOUSE:

But if you look at, for example, there's some numbers in here within D.C. metropolitan variation across the counties and it's very large. So that just raises the question -- we've gone around this racetrack many times, and should we be at the metro area level. Then if you're at the metro level everybody goes to Fairfax and avoids Prince

George's, and if you're at the county level it's just the reverse.

The other point I wanted to make was -- there was a couple more -- in response to Dan and Scott.

A health plan is not necessarily a health plan, because small plans may withdraw because they can't make it and the large plan has economies of scales. Then there's some variation just from the demand side. In the Medicare market, for example, you may go less to markets that have a lot of retiree health insurance and Medicaid because the market size isn't as big there.

In general there's different markets for different kinds of services, which is part the problem here. The OB market is much more local than the market for cardiac surgery, but we're not really -- we can't really deal with that in any very good way. I'm kind of on this issue where you are or where Winston Churchill was with democracy: the county is the worse system until you consider all the rest of them.

MR. HACKBARTH: MedPAC, I think is at its best and contributes most where there is a right answer that we can help people see, and maybe bolster the people who against

the forces of evil who don't want to change. In this case we're not even sure what the right answer is. There have been a lot of analysts working at this for a couple of decades now and unable to come up with a clearly better answer. Our realm is not a technical one. We're not going to solve this problem so I think we ought to leave it to the analysts and maybe some day they'll give us something that we can rally around. That day is not here yet.

Does that makes sense to people?

Okay, thank you.

By happy coincidence we are exactly on schedule right now. Our last item for today is the workplan for assessing adequacy of the outpatient dialysis payment.

MS. RAY: Good evening. I am here to discuss outpatient dialysis payment issues and to present to you workplans for two studies. One is a new study and one is not a new study. We're looking for any questions or comments you may have on both of the workplan.

Just a brief refresher course about how Medicare pays for outpatient dialysis services, through a prospective payment called composite rate which was implemented by Medicare in 1983. It covers many of the services associated

with outpatient dialysis including nursing, supplies, equipment, and specific laboratory tests. Most patients receive hemodialysis in facilities; roughly about 90 percent of all dialysis patients. In hemodialysis a machine cleans waste from the patient's blood. The other dialysis modality is peritoneal dialysis and in that case blood is cleaned using the lining of the patient's abdominal cavity that acts as a filter.

On average, facilities receive about $130 per dialysis treatment through the composite rate. Facilities are paid for furnishing up to three hemodialysis sessions. For home dialysis, which is often administered more frequently than three times per week, like peritoneal dialysis payment is generally equivalent to -- the weekly payment for peritoneal dialysis is equivalent to three hemodialysis sessions per week.

Notably, the composite rate payment bundle does not include certain injectable drugs and these drugs are separately billable. These drugs were generally not available when the composite rate was implemented 1983. These drugs include erythropoietin that's used for the treatment of anemia, and the payment rate for that service

is set by the Congress. Other separately billable drugs are paid 95 percent of average wholesale price.

Just a little bit more background to put outpatient dialysis in prospective. In the year 2000, for freestanding facilities -- and again, that represents about 80 percent of all facilities, Medicare spent roughly $3 billion for composite rate services and they spent about $1.8 billion for injectable drugs. I apologize for the different years for this data by I tried to give you the most recent that I have.

In 2001, there were roughly 280,000 dialysis patients and about 3,900 dialysis facilities. Like I said to your previously, the average composite rate payment in 2002 was roughly $130.

Finally, ESRD patients receive all Medicare covered services so their total spending is roughly about $14 billion. Again, that includes all services, not just dialysis. That includes physician spending, hospital spending, post-acute spending.

MS. BURKE: Can I just ask a factual question on this? I just wasn't sure I understood. I just want to walk back through the numbers you just utilized. Estimated

spending for freestanding, which is 80 percent of the dialysis that occurs is essentially $4.8 billion. That's just for dialysis, setting aside their other services. The 282,000 dialysis patients in '01 are the patients using these freestanding or the totality?

MS. RAY: That's actually totality.

MS. BURKE: If you were to give me the total number for dialysis services what would it be?

MS. RAY: Dollars?

MS. BURKE: Yes.

MS. RAY: It's roughly about $14 billion.

MS. BURKE: No, for the non-freestanding. For the other dialysis -- this is the 80 percent?

MS. RAY: Right.

MS. BURKE: This is 80 percent for dialysis or 80 percent of the total cost of these patients for all services?

MS. RAY: The estimated spending numbers, the $3 billion for dialysis and the $1.8 billion four injectable drugs, those are based on claims submitted by freestanding dialysis facilities.

MS. DePARLE: How about the hospitals?

MS. RAY: I haven't gone through the same data exercise for hospital-based. I can come back and give you that exact figure at the next meeting.

MS. BURKE: So the 282,000 patients are a greater number than essentially is reflected by the 4.8?

MS. RAY: The 282,000 patients include those treated at freestanding facilities as well as hospital-based facilities, that is correct.

MS. BURKE: So if it's about, in our gross calculations here, about $20,000 per patient, that's actually not accurate because the --

MS. RAY: No. But I will come back at the next meeting and give you more complete information.

MS. BURKE: That's fine. I just wanted to make sure I understood these numbers.

DR. ROWE: May I also ask a -- do you know what the number is for the total expenditures for the patients? Not just the $14 billion for the dialysis treatments but the total expenditures.

MS. RAY: The $14 billion is for all Medicare covered services.

DR. ROWE: How does of that is for dialysis?

MS. RAY: Again,

I apologize for not having my numbers consistent because, again, that number is for both freestanding and hospital-based. I'll come back to you in December and --

DR. ROWE: It doesn't matter to me. In other words, I'm just trying to figure out, of the total health care expenditures of somebody with end-stage renal disease what proportion is for dialysis, whether it's in a hospital, freestanding --

MS. BURKE: A little under $6 billion.

DR. NEWHOUSE:

The little under half. Somewhere in the 40 percent --

DR. ROWE: Which is very different than in the commercial population.

MS. RAPHAEL: What is it in the commercial population?

DR. REISCHAUER: He isn't allowed to say that till later. Chaos has reigned in your absence. They've gone out of control.

But now that you're in charge, I want to just ask you one thing.

[Laughter.]

DR. REISCHAUER: 282,000 patients, 3,900 dialysis facilities but some of them are going somewhere else. This means the average facility has less than 70 people? Pretty small, mom-and-pop --

DR. ROWE: But they show up three times a week.

MS. RAY: I can actually at the next Commission meeting bring you more information about that. We can pull some data out from CMS's facility survey that reports patients and number of sessions provided.

I'm here today primarily to discuss two workplans. The first study is not new for the Commission. This study fulfills our statutory mandate to annually examine the adequacy of the composite rate and make a recommendation to the Congress about an update. This will be in our March 2003 report.

The second study is new and it's focused on examining the relationship between payments, costs, and quality of care. I will be discussing the workplan for the study in greater depth at the conclusion of my presentation.

Just to briefly review how we go about conducting our update analysis, the goal of the analysis is to make a

recommendation about the composite rate payment for 2004. I will follow MedPAC's two-step approach that we use for other services in Medicare that we make an update for like hospitals, home health, and SNF. The first step is to assess whether Medicare's payment are too high or too low by estimating current payments and costs, and by assessing market conditions. If we think it is either too high or too low, our update recommendation could include an adjustment to the payment rate.

In the second step we try to predict the change in efficient provider's cost in the next payment year. Each part of the process can result in a percentage change. They are summed to determine the final update recommendation. Commissioners will be making the update recommendation at the January meeting and I will be presenting you data both in December and January.

I'd like to briefly outline the steps we use to estimate current payments and costs. I think it's most important to note that we include payments and cost for both composite rate services and separately billable drugs because the payments and costs of the services are important for dialysis facilities. MedPAC began to consider the

payments and cost of separately billable drugs in its analysis two years ago.

Just to give you a frame of reference, in 2000 roughly 40 percent of dialysis facilities' payments were for separately billable drugs, and this share has increased in the short time that we've looked at this between 1997 to 2000. Hopefully we will have 2001 data to present you in December.

Two project costs for 2003 we will assume that providers' costs will grow at the same rate predicted by the dialysis marketbasket index. This assumption seems to be sound. In last year's analysis we looked at the growth of costs, providers' cost between 1997 and 2000 and found that was similar to the growth in MedPAC's dialysis marketbasket index.

Finally, to model payments for 2003, we'll do that to reflect current law and current law does not change the composite rate between 2002 to 2004.

MR. HACKBARTH:

Nancy, I'm sorry I zoned out for a second I think. Could you just say again what you said about the assumption that costs will grow at the rate of he marketbasket? Is

that a good assumption?

MS. RAY: We think that's a good assumption. We really have no other hard evidence to base that assumption on. Last year when I looked at the rate of growth of provider's cost that matched pretty closely the rate our marketbasket estimated.

We also look at the appropriateness of providers' costs and we will assess changes in providers' costs for composite rate services and injectable drugs between -- we'll extend the period now and look at it from 1997 to 2001, and we'll go ahead this time around and compare these changes to the growth in MedPAC's dialysis marketbasket. To examine trends in product change we will look at measures of staffing, at dialysis treatments per station, at total treatment per employee, and information about the length of dialysis sessions between 1997 to 2001.

We will also consider broader measures to look at the market conditions providers face. We will assess trends in the entry and exit of providers between 1993 and 2001 using data from CMS' facility survey. When we do this we'll look at the composition of dialysis providers in terms of their profit status, affiliation, and where they were

located, in rural versus urban areas. And we'll analyze the growth in the number of facilities, again, between the period of 1993 to 2001.

We will try to evaluate the characteristics of facilities that have opened during this time period and facilities that have closed during this time period. Of concern is whether facilities are not opening or are closing where a greater proportion of Medicare beneficiaries are treated.

We'll try to look at providers' capacity to furnish dialysis and we'll do that by examining changes in the total volume of dialysis treatments between 1993 to 2001. And we'll also look at changes in payments for separately billable medications between 1997 and 2001.

Staff will present evidence about beneficiaries' access to high-quality care. Throughout the year I monitor published literature for evidence of systematic problems for beneficiaries accessing care. I also speak to providers about this issue in great depth, and I will also go ahead and present updated clinical performance indicators on dialysis adequacy and anemia management that's annually collected and published by CMS.

Finally, we will look at providers' access to capital. Access to capital is necessary for dialysis providers to improve their equipment and to open new facilities to accommodate growth in the number of patients requiring dialysis. Staff propose to focus this analysis on the four national for-profit chains which account for more than half of all facilities. Information we propose examining include the growth in the number of their facilities, the number of patients they treat, their earnings, and their bond ratings.

In the second part of our update framework, we account for providers' costs changes in the next payment year. To estimate inflation and input prices we will probably use MedPAC's marketbasket for dialysis services which comprises components from price indices for hospitals, skilled nursing facilities, and home health agencies. CMS' report that's due to the Congress on broadening the payment bundle also has a dialysis marketbasket index in that report, but my understanding is that report is still being reviewed within the agency.

We'll also qualitatively assess the impact of other factors on providers' costs in the next payment year

such as new medical advances, one-time factors, and productivity improvements. Again, throughout the year we monitor evidence that gets suggest that providers' costs are expected to change significantly due to any of these factors.

At this point I'd like to shift gears a little bit and talk about the second study. This is a new study that you're seeing and I guess I'd like to just briefly talk about the background and rationale for us doing this study. This study was motivated out of questions about what is going on really with the relationship between the decline in the payment rate, the increase in providers' costs, and therefore the slow decline in the payment to cost ratios throughout the '90s. But it the same time throughout the '90s, the improvement in quality of care.

I'd just like to review a couple old numbers with you that we published last year. Payment to cost ratios for composite rate services and separately billable drugs declined from 1.09 in 1997 to 1.05 in 2000. By contrast, quality of care improved. The percent of patients receiving inadequate dialysis declined from 32 percent in 1990 to 20 percent in 1999.

This study was also motivated out of the commissioners' discussion at the retreat about what is an efficient provider. When you look at the characteristics -- and it was motivated out of interest to look at the characteristics of facilities that furnish high quality care. In our analysis we've noted there is variation in providers compost rate cost per treatment. We're interested to examine how quality of care is different or is the same for those facilities that use fewer resources compared with those facilities who use more resources. As has been noted in the literature, higher cost does not necessarily mean better quality.

Other folks have looked at some aspect of this issue, specifically quality of care and the characteristics of facilities but they haven't specifically included the association of Medicare's payments and providers' costs in their analysis so this is new work.

So like I said, we'd like to begin to explore this relationship to see if there is any link between payment cost and quality of care and this is our first step in doing so. We think that ESRD provides us with a unique opportunity to look at these variables because CMS collects

information on quality of care because we have providers' cost reports and because we have been on Medicare's payments. Potentially we can learn, hopefully, a little bit about what we learn here to other provider groups.

This analysis will use data from the 1999 to 2001 provider cost reports and Part A and Part B claims. Providers' costs will be measured in two ways: composite rate services only, and then composite rate services and separately billable drugs. Quality of care furnished to dialysis patients will be assessed using a number of different processes and outcomes including adequacy of dialysis and outcomes of anemia management, risk of hospitalization, and rates of referral for kidney transplantation. We have contracted with Chris Hogan to help us run through the data and conduct the statistical analyses.

That concludes my presentation and I'd be happy to take any questions or comments.

DR. ROWE: I have one or two comments, Nancy. First of all, this is comprehensive and it's excellent. In my work I interact with big dialysis companies, as you know, a fair amount. We cover dialysis for, I think it's the

first 30 months or so, before patients become Medicare eligible. And we pay a fair amount more than Medicare so there's a fair amount of interaction. Nancy, as all the commissioners I'm sure are aware, is very respected, if not feared, in the industry.

I don't know how much of a change this is but I think it's at least a mindset change. I would like to ask you, Nancy, as you go forward, if it's not too much work, to change your focus as you look at this. I believe that Medicare, the intention is for this to be the end-stage renal disease program, but it gets discussed and analyzed as if it is the dialysis program. I think that we need a broader focus on the entire experience of the patient who is the Medicare beneficiary.

Less than half of the expenditures go for the dialysis treatments, and that these individuals have a tremendous amount of comorbidity and they have a lot of hospitalizations and shunt problems and infections and a lot of other antibiotic use for peritoneal dialysis related infections; a lot of other stuff that happens to these patients that is not directly dialysis related. It seems to me that we should be looking at the patient's experience as

the end-stage renal disease patient as supposed to the dialysis patient.

I can't specify for you exactly how that would change the result, but it seems to me to be clinically a more appropriate view, and it's really what it's all about. Because it may be that we should spend more money on dialysis and that we would be then spending less money on hospitalizations, or infections, or some other complications, and the patients would be better off and the whole program to be saving money. So I just think looking at the dialysis piece without a more comprehensive view seems --

I have, as Nancy knows and most of you don't unfortunately, I have way back in my history the fact that I am a board certified nephrologist, so I did this for a little while a long time ago. In the absence of Ted Lewers that would be my suggestion.

DR. NEWHOUSE: Nancy, in terms of this slide, my sense is that one of the things that's influenced quality here is in fact CMS's effort to focus on quality of care and develop indicators for this part of the program. It's my sense anyway, although it's just a gut feeling is that

that's had more to do with quality than anything that's gone on on the payment policy side, but I don't know how to test that. But I think it certainly has to be recognized that they have developed these quantitative measures, or they've started to use the quantitative measures in administering the program.

I have a second comment but you look like you want to respond to that.

The other comment really was how our prior recommendations here which I certainly thought were right on target have not gone anywhere at why that is. We basically said in the past, we should bundle the injectable drugs in and we should risk adjust for the characteristics of the patients. Nothing has happened, I think. You're going to tell me something has? That would be great.

But my question was, if nothing had happened, was this an issue with CMS, whether they disagreed with it or thought they couldn't administer it, or whether it was an issue with the Congress that didn't want to do it.

MS. RAY: CMS has prepared a study that looks into issues related to broadening the bundle. That study was to due to the Congress in July. My understanding is that it's

still under review within the agency. So the progress has been made and I don't think our recommendation fell on deaf ears. So I think the next step is to wait for CMS's study and to review it once it's available to the public.

MR. HACKBARTH: Nancy, do you know if the draft that they're looking at goes beyond expanding the bundle to the risk adjustment piece that we've also recommended or is it just about the size of the bundle?

MS. RAY: I don't know. My sense is it's just broadening the bundle, but I wouldn't swear to that.

I'd like to go back to your issue about quality of care. I think that CMS's publishing the measures has had an impact. You still do see regional variations in quality of care however. But you're right, I think it has had some effect.

MS. BURKE: I checked back through because I didn't recall reading this last evening when I read it, and that is the issue of the difference in payment rates between freestanding and hospital-based facilities. When we did the amendments in '81 there was a fair amount of discussion at that time and the difference between the two. There had been a history of a series of issues, reuse and a variety of

other things that had occurred.

In the document it was not clear to me as we look at this issue and this list of issues, whether the question of whether or not there continues to be a difference, other than the obvious cost allocation issues which occur presumably in a hospital-based facility, but whether there is -- there is now a differential of $4 or some amount between the two rates. Whether there continues to be a basis upon which that difference is presumed to be made, whether that is an issue that ought to be rethought.

Now one of these questions is an acuity question. There had been for long period of time the presumption that the patients that were being served in hospital-based units had a higher acuity. I don't know whether that remains the case today, whether anyone has any idea whether there is a difference between the patients that are seen. A risk adjuster would deal with that issue irrespective of the location of the treatment.

But I wondered as we look at payment issues whether that issue has recurred, whether people have looked at whether or not there is a basis for the difference in the rate. It is something Congress got in the middle of

historically, but I don't know whether or not any work had been done subsequently on what the difference ought to be, whether there ought to be one, and whether it ought to be something ultimately that's dealt with through risk adjustment or not. I didn't see in the discussion -- it's almost entirely based on the freestanding issue rather than the hospital-based. I wondered -- I mean, it's 20 percent, but its 20 percent.

MS. RAY: Right. The $4 difference has not been revisited by anybody since then.

MS. BURKE: Since '81?

MS. RAY: That's correct. I think at this point what we said two years ago when we made the recommendation for refining the payment design in the 2001 report where we made the recommendation for the broader bundle, at that time I didn't see any real studies showing differences in patient acuity between hospital-based and freestanding facilities. I didn't see any published evidence in peer review suggesting that there were significant differences.

MS. BURKE: So we assumed that the rationale for the $4 remains the rationale we had in 1981? I knew we were brilliant at the time, but I would have thought time would

have passed even me by.

MS. RAY: What MedPAC's recommendation said in 2001 is that payments should be based on efficient providers' costs, and that payment should be adjusted for those factors that are known to affect cost. We did have evidence, for example, that providers' costs do differ based on the frequency of dialysis, based on the dose of dialysis, based on dialysis modality.

MS. BURKE: But does that differ between the location of service?

MS. RAY: No, I have not seen that those variables differ by the location of service. What we said specific to hospital-based and freestanding in the 2001 report is that's an issue that CMS needs to address when they're figuring out what the payment should be, to determine whether or not it still appropriate for there to be a difference between freestanding and hospital-based.

MS. BURKE: We don't know whether or not the current study will in fact address that issue?

MS. RAY: I don't know that.

MS. BURKE: So I guess I would just suggest as we go forward with this that at some point we ought to opine on

the fact that someone ought to ask that question.

MR. HACKBARTH: Any other comments or questions?

MR. FEEZOR: Just to underscore Jack's observation about looking at the total program. I thought that was profound and we need to do that.

MR. HACKBARTH: All right. Thank you, Nancy.

It's now time for the public comment period. As always, I'd ask that you keep your comments brief.

MR. ZIMMERMAN: Yes, I will be brief. My name is Eric Zimmerman. I'm an attorney with McDermott, Will, & Emory here in Washington. I represent the American Association of Ambulatory Surgery Centers so I want to go back and address some of the points that were raised during that discussion.

Four quick points, and I promise I will make them quick. One clarification to a statement made by staff. That is that there is now, effective October 1st, nine different payment groups used for ASC services. One of the slides actually showed the payment rate for the new ninth payment group which is on the top end. But just to clarify that.

Second, let me just address the discussion about

growth in ambulatory surgery centers. In addition to some of the points that were raised during the discussion such as patient convenience, physician efficiency, and the like, I think you also have to recognize that in the scheme of things you're dealing with a relatively young program here, a relatively new concept. The program has been around only 20 years and for much of those early years, the ASC list -- that is, the list of services that Medicare would pay and ASC to perform, was very limited. In the early years it was about 400 procedures.

So as that procedures list grew, so too did the opportunity to do services in ambulatory surgery setting. The practicality of doing a broader range of services. So I think you have to look at the growth of the list commensurate with the growth in ambulatory surgery centers as a major explanation for that.

Third, let me touch on the discussion about the survey that CMS did in 1994 that was the basis for rates in 1998 as well as their statutory obligation to do a survey now. There's a couple of explanations as to why CMS has not done a survey since 1998. I think first really is a practical matter. The very same staff at CMS who are in

charge of administering the ASC program, at least in a reimbursement sense, are the same staff who administer the outpatient PPS system for hospitals. As you all know, in recent years I think they've been completely overwhelmed with trying to get that system online. And given the priority of that system vis-a-vis the ASC system, unfortunately I think the ASC system has taken a real backseat.

But in addition to that, I think there was a collective recognition among CMS staff, people on the Hill as well as those in the ASC community who I represent that there was a real flaw in the survey and that perhaps a good survey instrument really cannot be created here. As the 1994 survey indicated, CMS just didn't know what questions to ask, the ASC industry just didn't know how to answer the questions.

You have to recognize, some ASCs are three or four ORs, freestanding, sophisticated facilities. A very large percentage of them are single specialty, one OR, extensions of a physician's office that don't have cost tracking systems or accounting systems much more sophisticated than a physician office, so really couldn't respond to the ASC

survey. As a result CMS actually had to extrapolate rates for over 60 percent of the procedures on the list in 1998, which was also one of the big criticisms of the proposed rate rebasing.

DR. NEWHOUSE:

What was the dollar volume of those 60 percent?

MR. ZIMMERMAN:

They were certainly lower volume procedures. They had data for many of the higher volume procedures. Like they had no problem collecting data for cataract. We could certainly currently argue upon how reliable the data was, but they had ample data on that. Sixty percent represented probably the lower end of the spectrum. Nonetheless, it was 60 percent of the procedures.

My final point is about the rate update. There was a lot of discussion about the fact that ASC rates had been updated each year by an inflation factor since 1986, which is for the most part true. However, in the Balanced Budget Act of 1997, Congress included a provision that held the CPI update to CPI minus two for a five-year period. Because inflation was relatively low in those years, 1997 through 2002, the inflation updates were, in most of those

years, less than 1 percent, and in one of those years, because it was so low, CMS decided they weren't going to do an inflation update at all, so the rates weren't updated at all.

So again, while it's true that rates have been updated, recognize that in real terms we're talking about 1 percent updates or less over the last five years. This is the first year, 2003, that CMS has gone to back to updating rages with a true inflation adjustment because the BBA provision expired.

MR. CHINCHANO: Good evening. I'm Dolph Chinchano with the National Kidney Foundation. I'd like to point out that an additional factor that may have contributed to the outcome improvement for dialysis patients in the last five years has been the publication and dissemination and adoption of practice guidelines, including those that have been promulgated by the National Kidney Foundation.

I'd also like to echo support for Dr. Rowe's position that the Commission look at the total experience of the ESRD patient, and I am particularly pleased that Nancy is planning to look at the issue of access to transplantation which is very important to the National

Kidney Foundation and to the patients that we serve.

Thank you.

MS. McILRATH: I'm Sharon McIlrath with the AMA. I just want to make a few quick points about the volume study. One thing, I wonder whether you want to focus only on physician services, or if CMS does not remove drugs from the SGR, I wonder whether you want to expand and look at the volume and what's happening with the drug prices that are also included in the SGR.

Also just in terms of when you're looking at things and some of the confusion -- I know one of the things that was mentioned was rehab services. We found last year, and I think it was probably true this year as well, or two years ago, 2000 and 2001, that there was a large increase in physical therapy services. It turned out that what had happened was that the BBA changed a lot of the billing rules and a lot of people who had previously been billing as a facility under Part A switched over and were billing as individuals under Part B. So it looks like there's a big increase but it's really a shift.

Another point just on some other things that you might want to look at that might be driving volume, on the

beneficiary side, in addition to age I wonder if there aren't some patient characteristics. You see a lot about the increase in the number of diabetics, the number of people with obesity that are in the program now. I think as you see more immigrants you may see some greater numbers on the diabetic side. The ESRD stuff, there are more patients with kidney disease that are in the program and that might also be driving some of the differences.

Also, some of the quality improvement programs, maybe in the long run they have a cost-reducing impact but they may be increasing the use of physician services. I'm thinking of some of the standards for care of people with diabetes and maybe even some of the kidney standards.

MS. GAMPEL: Hi, I'm Gwen Gampel and one of my clients is the Renal Leadership Council which is made up of the large dialysis providers that provide 40 percent of care to Medicare beneficiaries. I would like to say that the decline in the payment to cost ratio has in fact negatively impacted the ability of providers to improve quality of care. As the National Kidney Foundation, as Dolph pointed out, the renal community came together in the 1990s and came up with quality standards, and all facilities then

implemented those quality standards on the adequacy of a dialysis treatment, anemia and other factors. That's why quality has improved despite lowering payment to cost ratios.

But one of companies we represent is Gambro Healthcare. That's a Swedish-based company and we did bring in people to talk to Nancy about the fact that this company in Sweden is able to use technology that is improving quality that because of the Medicare payment prevents this Swedish company from bringing this technology into the United States for their 500 facilities in this county. That has to do with cardiac monitoring and vascular access. These are two major reasons why this patient population is hospitalized and why the total ESRD dollar, more is spent in hospital than on the dialysis treatments.

So I would definitely agree with Jack Rowe's comments -- sorry he had to leave -- that if you paid better on the dialysis side there is no question but that you would save money on the hospitalization side. Every study shows the more adequately the patient is dialyzed, the less you need to spend on drugs for that patient population and the less hospitalizations there are for that patient population.

So I hope that you will let Nancy look at that issue because I think you could -- if rearranged the total dollars, spending less on the hospital side, more on the Part B side, that you would definitely improve the outcomes of this patient population.

Thank you.

MR. HACKBARTH:

Okay, thank you. We're adjourned until tomorrow morning at 9:00.

[Whereupon, at 5:27 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, November 8, 2002.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, November 8, 2002
9:07 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning everybody.

First up this morning is a mandated report on providing choice for SNF services under the M+C program. Tim?

MR. GREENE: Good morning.

I will be discussing an issue we are addressing in a mandated study. We've completed the work and will deliver our report to Congress in December if the Commission approves.

An issue has arisen of reported difficulties Medicare+Choice plan members have encountered in dealing with their health plans. When hospitalized, some of these beneficiaries require skilled nursing facility services at discharge. Plan members who reside in continuing care retirement communities, CCRCs, or SNFs often wish to return to specific facilities. Those living in CCRCs often prefer placement in the SNF on the campus of their retirement communities.

Those living in SNFs before hospitalization might seek to return to the original facility at which they lived. At times, however, beneficiaries have found that plans require that they be placed in a nursing facility in the

plan's network, rather than in their home SNF as they wished.

BIPA requires that Medicare+Choice plans cover skilled nursing facility services through a SNF chosen by the plan's member. CMS published a proposed rule on October 25th, implementing this provision and other sections of BIPA affecting Medicare+Choice plans. The law required that MedPAC conduct a study analyzing the effects of the provision on Medicare+Choice organizations. We were to look at the impacts on cost, administrative procedures, contracting, and benefits in plans. Our report containing our findings is included in the letter in your briefing materials.

CMS data do not identify Medicare+Choice members who use CCRC or SNF services. We therefore interviewed administrative staff at 10 CCRCs in nine states. We also surveyed managers and medical staff at four national managed care plans. Finally, we interviewed representatives of major long-term care and managed care associations.

Disagreements between managed care organizations and members with regard to post-hospital SNF placement have arisen in several states. We saw this at the last meeting, but it's the summary that I'll be presenting here as well.

Many states responded to these problems by enacting laws in the late 1990s. These laws generally cover all managed care plan members, apply to CCRC or SNF residents, and deal with referral, payment, or both.

Laws such as the one in New York require that members' physician refer a CCRC resident to the community's nursing facility. They require that facilities accept plan payment rates.

Statutes such as that in California require that plans reimburse facilities preferred by members who reside in CCRCs.

In BIPA, the Congress established similar rights for members of Medicare+Choice plans in all states. The BIPA protections apply to CCRC and SNF residents and deal with payment issues.

The issue of SNF placement for M+C plan members may have diminished in importance in recent years. CCRC staff report that problems of return to SNF now occur relatively rarely, although they may have arisen more frequently in the past.

Most CCRC staff reported no recent events at their own facilities. Managed care plan staff indicated they've rarely encountered problems associated with placement of

members in retirement community nursing facilities. Both plan and CCRC staff indicate that they have generally been successful in resolving disagreements through negotiations. This is in the period before the BIPA legislation.

Plan staff note advantages in placing beneficiaries in nursing facilities with which the members are already familiar before hospitalization. However, some express concern with potential quality problems in monitoring and coordinating care among non-network providers.

Our conclusions, which are our response to the Congressional mandate, we believe that the BIPA provision has not had a major impact on Medicare+Choice plans. It has not imposed significant new costs on managed care organizations. Staff at large plans report that they often contract for out-of-network care for skilled nursing services for Medicare beneficiaries.

This, plus the fact that the BIPA provision requires that plans reimburse facilities at their standard contract payment rates, leads us to think -- and our interviews confirm -- that there would not be, and apparently hasn't been, any significant cost impact on the plans.

As a result of these considerations, there were no reports of major administrative burdens attributable to the impact of BIPA. Similarly, plans do not report any impact on contracting decisions. Because there are no major administrative or cost burdens from the provision, there have been no major effects on additional benefits offered by plans to Medicare+Choice members.

The nursing facility return issue is of modest proportions and may have declined in recent years. Managed care practices, and the enactment of state laws in the late 1990's may have helped ameliorate problems. The law affords protections to beneficiaries. It may have benefited some communities in their dealings and negotiations with plans. It does not appear to have negatively affected either Medicare+Choice plans or retirement communities.

Thank you.

MR. HACKBARTH: Any comments or questions?

MR. FEEZOR: Tim, just one question. Where there is a return to a SNF or a CCRC that is not a recognized participating provider institution, are the Medicare+Choice plans requiring any additional release of liability that you know of?

MR. GREENE: Not that I know. What we were told

is that many plans already contract on a case-by-case basis with facilities so though this appeared at first to be an unusual situation, the BIPA mandate on plans, it appears to be fairly common practice to negotiate case-by-case with facilities. And we've not heard any reports of special provisions.

DR. REISCHAUER: Just a little editorial comment. I think this is making a big deal out of not much and we've gone over it several times but at several points in this letter we say that the problem may have diminished in the last few years.

Unambiguously, it has to have diminished because the number of people in Medicare+Choice has fallen. So I would say that to the extent that some people might have thought it was a problem before, it's even less of a problem today.

MR. HACKBARTH: Although that isn't our recommended solution to the problem.

[Laughter.]

MR. GREENE: We're not making a recommendation. We can say what we wish.

MR. HACKBARTH: Any other questions or comments? So this will go in December so this is our last look at

this. I think we need to take a formal vote to adopt this as the Commission's response to the request for report.

All opposed to the recommendation?

All in favor?

Abstain?

Thank you.

Next up this morning is PPS for inpatient psychiatric facilities.

DR. KAPLAN: Good morning. The purpose of this presentation is to bring you up to date on the prospective payment system for inpatient psychiatric facilities and to tell you about our workplan for the mandated report to the Congress on the PPS.

As you know, inpatient psychiatric facilities specialize in treating patients with mental illness. To be admitted, patients must be considered to be a danger to themselves or others. These facilities also provide treatment for patients with drug and alcohol-related problems.

Inpatient psychiatric care is also provided by general hospitals in what are called scatter beds. Acute care hospitals are paid for these patients according to the DRGs. Currently, specialty psychiatric facilities are

exempt from the acute care hospital PPS and are paid according to their historical per case costs.

The Balanced Budget Refinement Act required CMS to do two things about a PPS for inpatient psychiatric care. First, it required CMS to report on a PPS to the Congress and it also requires CMS to implement a PPS that would pay on a per diem basis.

The BBRA conference report required us to evaluate the impact of the PPS described in the CMS report. CMS issued their report on August 29, 2002. Our report is due to Congress March 1st. However to be more useful to CMS and to the Congress, we plan to identify major issues for a letter report in January. When CMS publishes the regulation on the PPS, we will comment on their proposal. Once the PPS is implemented, we'll suggest refinements to the PPS as necessary as part of our regular work.

So basic volume and spending figures for 2000 are on the screen. About 300,000 beneficiaries used specialty psychiatric facilities that year. Some of these beneficiaries had more than one discharge. Medicare spends about $3 billion per year on beneficiaries who use specialty facilities. About 2,000 psychiatric facilities are Medicare certified and 75 percent of these are hospital based units.

On the screen is the number of facilities from 1995 to 2002. Freestanding hospitals include government-owned hospitals. The biggest change has been in the number of freestanding psychiatric hospitals which decreased 29 percent from 1995 to 2002. Hospitals have a greater number of beds than units so the reduction in beds has been greater than the reduction in facilities.

The 1986 to 2000 length of covered stay declined for psychiatric patients in every setting except government-owned psychiatric hospitals. Length of stay dropped by four days for scatter bed patients. The patterns of care and objectives of care appear to differ for these patients.

In hospital-based units and freestanding non-government hospitals, the length of stay dropped to about 11 days. In contrast, government-owned psychiatric hospital length of stay stayed the same from 1986 to 2002 at 17 days. CMS attributes the decline in length of stay in non-government psychiatric facilities to therapeutic changes and changes in treatment patterns. Therapeutic changes include new drug therapies and greater use of group therapy. Changes in treatment pattern include the impact of managed care and general changes in treatment practices.

CMS also points out that because government-owned

psychiatric hospitals case loads have a much larger share of beneficiaries with diagnoses of serious and persistent mental illnesses, such as schizophrenia, a reduction in length of stay for these facilities is more difficult.

CMS's development of a PPS for speciality psychiatric facility patients is based on a model developed by the Health Economics and Outcomes Research Institute for the American Psychiatric Association. The APA model uses a combination of patient-specific and facility-specific variables to predict per diem resource use. These variables are available from CMS's routinely collected administrative data.

Structurally this PPS system is similar to the way Medicare risk adjusts for M+C plan payments. The structure is different from the PPS for acute care hospitals. The APA model was developed by excluding government-owned hospital patients. Researchers developing the APA model examined care and all psych facilities and concluded that government psychiatric hospitals are different. The APA model explains 22 percent of variation in patients per diem resource use. Of course, with the per diem system, the big source of variation resulting from length of stay is already removed.

Another characteristic of the APA model is how it

pays on a per diem basis. It uses declining block pricing and pays a higher rate for the first two days to compensate for the higher costs of admission. After the first two days the daily rates step down as the care delivered is less intensive.

CMS plans two import modifications to the APA model including government-owned psychiatric hospital patients and using different comorbidities. Including the government-owned psychiatric hospital patients will probably make the biggest difference.

Our next steps will be to examine simulations by the Health Economic and Outcomes Research Institute using the model described in the August CMS report to Congress. The simulations will allow us to project the impact of that model on different types of providers and raise major issues. We'll discuss those issues in our January letter report to the Congress. Once CMS publishes the proposed rule, we'll be able to assess how well they deal with the major issues they raise and comment by letter. Once the PPS is implemented as part of our regular work, we'll suggest refinements as necessary.

I'm happy to answer your questions.

DR. NEWHOUSE: There's a clear step forward here

in using the per diem rather than the stay which, from what I know about this problem, is the correct choice.

I had two issues. One is on the declining block scheme. I wondered if there was any effort to explore a more continuous scheme, so you didn't have these what looked like cliffs at seven days, 14 days, and so forth. Rather, the rates would adjust in a more continuous fashion on length of stay.

The second point is a point I talked with the authors about. This is different from the risk-adjustment and the APCC because it uses the log of the per diem rather than the actual per diem. Which means when you go back to payment, you've got to get out of the logs. And there's some assumptions you need to make here that need to be checked, but that can be done downstream.

MS. BURKE: To start with I just had a couple of questions and then an issue. In terms of the numbers, the statistics that you cite, the 2,000 facilities, what percentage of those are government-owned?

DR. KAPLAN: One second. In 2000, 40 percent of the freestanding hospitals were government-owned. That's about 198 of 498 hospitals. And most of these were state hospitals, about 173 out of the 198.

MS. BURKE: So of the 2,000 facilities, about 198 are government-owned?

DR. KAPLAN: Yes.

MS. BURKE: So that applies across, not just to freestanding?

DR. KAPLAN: No, no, freestanding. Of the freestanding hospitals.

MS. BURKE: The 2,000 sites, only the freestanding? Or is this the totality?

DR. KAPLAN: No, that's all of it.

MS. BURKE: So of the 2,000 how many are government-owned?

DR. KAPLAN: About 200, so it would be about 10 percent.

MS. BURKE: I'm sorry, 2,000 includes both freestanding and hospital-based; correct?

DR. KAPLAN: Yes.

MS. BURKE: And the number you cited of 200 is of freestanding?

DR. KAPLAN: Yes.

MS. BURKE: So there are no government-owned hospital-based?

DR. KAPLAN: There are, but they're not the same

as the government-owned hospitals?

MS. BURKE: So they're not included in the 2,000?

DR. KAPLAN: They're included in the 2,000. They're not included in the 40 percent of the freestanding hospitals.

MR. HACKBARTH: Let me just make sure I understand what you're saying. There are 200 that are separate government-owned psychiatric institutions that have the really distinctive characteristics. The hospital-based government units would be much like any other hospital-based unit?

DR. KAPLAN: That's correct. It's about 10 percent of the total.

DR. REISCHAUER: The fraction of beds is a lot higher.

DR. KAPLAN: Yes. Yes, of the freestanding hospitals, government hospital beds represent almost 70 percent in 2000.

MS. BURKE: Of the 300,000 beneficiaries who received care, what proportion were in government-owned?

DR. KAPLAN: I can't tell you that from the information that I have.

MS. BURKE: About the block system, the method of

payment by essentially declining assets based on treatment which conceptually makes sense from what I recall of this as well. But I wondered whether there was any variation by diagnosis? Or did they assume that the reduction is essentially consistent across diagnoses? So that the intensity of the first two days is the same irrespective of your admitting diagnosis and the declining similarly? That seems odd to me.

DR. KAPLAN: I think, first of all, on a per diem basis they found very little variation when you talk about per diem payment or per diem costs, or actually per diem charges. And there was a table in your mailing material that showed there's basically about $1,000 a day.

DR. REISCHAUER: [inaudible] 10 percent.

DR. KAPLAN: Right, it varies by 10 percent, that's it.

DR. NEWHOUSE: There is an adjustment for diagnosis.

DR. KAPLAN: There is an adjustment for diagnosis.

DR. NEWHOUSE: So the percentage reduction is the same across diagnoses, but the absolute dollars are different?

DR. KAPLAN: Right.

MS. BURKE: But the base is different?

DR. KAPLAN: Exactly.

MS. BURKE: And then finally, in the proposal to essentially use different comorbidities by adding -- the references were to ESRD and HIV and diabetes and so forth, what comorbidities are now reflected that these would not be included? And how different is t? And I wondered what kind of impact that has?

DR. KAPLAN: In your mailing material, there's a table that has the model and it has all of the comorbidities and basically there comorbidities ideologies. Autoimmune, antigens, allergens, congenital, degenerative, degenerative, drug, alcohol, infectious, medical care, et cetera. So it's very different from the comorbidities that CMS is talking about using because CMS is talking about using specific conditions.

MR. DURENBERGER: I am back under the discussion section and because I don't know a lot about the subject I need to ask you a definitional question.

The discussion begins by setting out the fact that we're trying to define products and services, what we're buying and what do they cost, and so forth. The further discussion points out that traditionally certain kinds of

settings have been used for certain kinds of cases. This is part of what Sheila was asking about too, I think.

Also there's a point in there about the dwindling number of, or at least the relative lack of community-based services for people who come out of these facilities.

So my question, I think, is in the product definition part. Where in the continuum of the problems that are presented on admission to these facilities, where in that continuum do you diagnoses as a product? Where do you find the therapy? Where do you find the rehabilitation?

How do you define an outcomes? Or how do define value at the end of the process of assembling all these products over 17 days and turning somebody out into the community? Can you help me understand that?

DR. KAPLAN: I can tell you that this area has been probably more of a mystery than in the medical area. In other words, when we know that someone has had surgery, that's pretty clear cut as to what the product is. Maybe a little more mystery when we get into the people who are on the medical floors of the hospital and the surgical floors.

In the psychiatric hospitals it's more of a mystery. But more is known now than was known in the past. The thing that we knew about the product was that it clearly

looked in the past as if different types of facilities had different goals of treatment as well as different treatment patterns.

Now we noticed, based on a statistical evidence, that there has been kind of a convergence among the freestanding non-government hospitals and the hospital-based units. That they seem to be having more, treating the same type of patient and the same goals and the same treatment patterns. At least it appears that way statistically and that's what we hear anecdotally.

As far as the government-owned hospitals, they are in a position that they ultimately are the fallback, in the fallback position. They are the safety net hospitals and they cannot refuse hospitals. So their product is somewhat different and they take people who are more shall we say intractable, that can't be treated as well.

MR. DURENBERGER: Do they come out after 17 days or whatever it may be, having had an experience, and then a year later they come back? I mean, I'm asking this question as though I had a family member with a serious psychiatric disorder or whatever we call it. And I'm trying to make a choice and Medicare is signaling me it's X number of dollars whether you go here, there, or whatever. I don't see in the

discussion the benefit to me as a beneficiary. I see a discussion about the services and what do we have to pay for the services that are delivered in these kinds of settings.

But I don't get the context of what I'm going to get at the other end after I've completed my 17 days or whatever the average is that we may be paying for.

DR. KAPLAN: Well, the 11 days that we're paying for in the hospital-based units and the free-standing hospitals, the product that you're getting is that these people are stabilized, that they have returned to a steady state which is hopefully at the steady state prior to their incident and are discharged to the community. With the government hospitals they are probably more difficult patients, harder to get to the steady state. And you may be getting a different product. We believe it's a different product. It's certainly a different treatment pattern.

Does that help answer?

MR. DURENBERGER: Not really, but it sounds like a subject I could explore for a long period of time. I'm getting the impression that somebody has to be hospitalized. Somebody with a problem, with a mental health problem, does something that forces them to seek hospitalization, or their family to help them seek hospitalization.

So they go to one of these hospitals and their Medicare eligible and they get a payment for it, and they come out at the other end. And for some period of time they won't be "problem" anymore. But I don't see that these particular facilities have added any dimension, using your medical example, to the cure.

DR. KAPLAN: I don't think that there necessarily are cures.

MR. DURENBERGER: That's not their function?

DR. KAPLAN: Well, I think we have a -- we don't know very much about how to cure mental illness.

DR. ROWE: Dave, why look at it any different than some other medical condition that gets worse from time to time like congestive heart failure? There's only one cure for that, it's a heart transplant. Most people don't need that. You have an episode of congestive heart failure, get in the hospital, get medication, get some structure in your diet, a little rehab and you get better and you go home. You may, in fact, have another episode or systemic lupus, multiple sclerosis.

These are chronic diseases that have exacerbations from time to time. You get admitted to the hospital with your multiple sclerosis exacerbation. You get managed, you

get treated, you get better, you go out. We don't need to have a dichotomy of mental psychiatric illness from other forms. It fits the same model, I think.

Does that help at all?

MR. DURENBERGER: Yes, it helps clarify what I'm hearing and I think I have it in the context that I was looking for. Because then the other part of that question was about community-based facilities and so forth and that isn't really our problem. That's simply a reality that exists that probably forced more people into the Medicare-financed facility. Thank you.

DR. KAPLAN: Let me also make the point that Medicare is not the primary payer in most of these facilities.

DR. NEWHOUSE: This may help, David, I'm not sure. But it relates to a second point that I want to make also, which is that there is a potential here -- I think what's going on between the government and the non-government is what Sally said, which is there's an unmeasured case mix difference.

So if I'm starting from the point of view of this is a family member and I want to know what I'm buying for the extra six days in the government hospital, for that

specific person I may not be buying anything. But basically the people that are going there are different people in ways that these variables aren't standardizing or picking up.

I think that's the bulk of what's going on, I think.

MS. DePARLE: Are they different people or is it just where these things are located?.

DR. NEWHOUSE: Nobody can really be sure but the people I talk to think they're different people.

MS. RAPHAEL: Because we bring them out of the hospitals and we try to follow thousands of these people and manage their medication with them, which is sort of key. And my experience is they're different people.

DR. NEWHOUSE: But then I wanted to go on to a second point that's related to the different case-mix point, which is I notice there's a fairly substantial coefficient on the teaching variable. I suspect that's picking up some kind of unmeasured case-mix difference. That should be something we should want to try to correct for in some other way, since it will offer the hospital incentive to add to its house staff, which we've don't particularly want. We want to stay neutral on that.

My suggestion is that -- maybe this was tried, I

don't know, that one try to break down the diagnoses further than the DRG level.

DR. KAPLAN: I think that's a limitation of the data, to tell you the truth, having worked with the claims for the psych patients and the MedPAR data from the psych patients, there's not tremendous -- I don't know how you would do it necessarily.

DR. NEWHOUSE: Don't we have ICD-9? I'm thinking of what we did on --

DR. KAPLAN: Yes, we do have ICD-9.

DR. NEWHOUSE: I'm thinking of what we did, that Julian did, on the teaching hospital stuff a few years ago.

DR. KAPLAN: The APR DRGs?

DR. NEWHOUSE: That's what we used there. That was kind of off the shelf. I don't know if they will work here, but my suggestion is that we try to find something to knock down. Putting in an incentive to add house staff where that isn't really the intent of the variable but rather what the variable is probably doing is picking up some unmeasured case-mix differences. Or maybe there's a difference in product. I don't know. It would be nice to try to work on getting that coefficient down.

MR. HACKBARTH: If, in fact, the patients served

by the government hospitals are different in ways that we're not measuring with these models, what do we do? This is apparently not a new insight. I gather that MedPAC before, and ProPAC have made this observation. Do we have any idea what CMS plans to do with the government hospitals?

DR. KAPLAN: They're planning on including them in the model at this moment, and that's one of the things we'll be looking at with the revised model or the modified model, to look at that model with and without the government-owned hospital patients to see what difference it makes. Once we see what the effect of that is we can see whether a remedy is needed or not.

CMS doesn't really have any choice because in the legislation it basically said put these hospitals in a PPS. But I think we wait until we see what the results are from the new model.

MS. RAPHAEL: I had your question, and just one other question. Sally, in the text you said that 30 percent of the freestandings have left, I think, since 1995. Do you have any sense of what the prospective payment system impact might be on access? Because I also remember, I think it was in our June report, one of the areas we cited that was a problem for Medicare beneficiaries was access to mental

health services.

I'm wondering if you think it would improve access or just be neutral?

DR. KAPLAN: I think we're going to be able to see how different types of facilities are going to be affected, assuming that the model will be what -- what is in that report might be further refined, but we'll be able to see what the effect is from there and then try to extrapolate from that as to what we think the effect on access is going to be.

If I remember correctly, part of what we said in the June report was really related to outpatient mental health services and not really inpatient mental health services, which of course is a whole different ball game.

MS. DePARLE: I followed the discussion about case-mix and it sounds like there is a difference among the patients who go to the state or government-owned hospitals but speaking from my own experience -- and I'd see what Mary thinks -- I do think there is sometimes a distinction based on the location of the person.

There are areas, at least in Tennessee -- Pete's here -- where there's rural area and there isn't anything except the state hospital in Balver, or wherever it was.

And that's where people in West Tennessee would go, unless they lived in Memphis and then went to one in Memphis.

This may be to some extent before the for-profit companies came into it but I do think that we might see that there was some difference for rural beneficiaries, that they would be more likely to go to some of the state facilities. I don't know.

DR. WAKEFIELD: I don't have any data on that but I'd say I think your point is fairly accurate, at least in a state like the state where I live. Obviously, there are larger metro hospitals in about four cities in the state have inpatient psych facilities. But for all of the other small rural hospitals across the state, there's very minimal capacity that they have for treating these patients.

So generally speaking it's a transfer of a patient, especially if they're in a crisis mode, into an ER in a local small rural facility and then a referral. Could be referred to one of those metro hospitals, but there's a lot of movement into the state facility. I know that, having worked in small rural hospitals, myself. That's where we tended to transfer our patients.

So I wouldn't be surprised of some of what you're talking about, in fact, is part of that of that phenomenon.

MS. DePARLE: And I don't know how significant it is, or whether it matters, but that is the observation.

DR. WAKEFIELD: But that is the place where a lot of patients in our small facilities end up being transferred to.

MR. HACKBARTH: So where that's true, in states where that's the case, even within the government-owned sector, then you would have perhaps different types of patients. Some from rural areas that didn't have a local psych facility available and then other patients with much more serious problems all intermingled in one institution.

MS. DePARLE: Right, it may or may not track with the acuity of the patient.

I also wondered whether this any way of understanding whether any of these patients that are in inpatient psych facilities are the same patients who might be admitted into nursing facilities as well, given their diagnoses.

DR. KAPLAN: They have to be deemed to be at risk to themselves or others to be admitted to an inpatient psych facility. So they may live in a nursing facility. Although I have to tell you, they aren't easy to get into nursing facilities, based on what we heard from our focus group that

we talked about yesterday. People who had psychiatric problems who were different to get in pre-PPS and difficult to get in post-PPS in the nursing homes and the SNFs.

MS. DePARLE: That sort of relates to Senator Durenberger's question about whether they have a good place to be when they're not in there.

Finally, have you looked also at the partial hospitalization benefit recently?

DR. KAPLAN: No.

MS. DePARLE: Because I'm wondering whether there's any correlation between the decline and the number of available beds starting in '95 and growth in partial hospitalization because that was around the time we started to see it.

DR. KAPLAN: I don't think there's been much growth in partial hospitalization, from what I've heard. I've heard that it's been difficult.

MS. DePARLE: There was in the mid-90s, in certain states. It may be limited, but it was Texas, Florida, a few southern states in particular. Maybe a little in California. I haven't looked at it in a while

DR. KAPLAN: My understanding about the decrease of freestanding hospitals from '95 to 2002 is that there was

a large for-profit chain that went bankrupt during that period and closed over 50 hospitals and that that was a lot of the decrease.

DR. REISCHAUER: I think the focus of this, if I'm not wrong, is the question of can we design a new payment system that will pay appropriately for care delivered in different types of facilities to different types of patients. Yet, there's sort of an implicit subplot in here which seems to focus on has the existing system paid adequately. Here I'm talking really about all the discussion of numbers of facilities that have closed, et cetera.

That's interesting background information, but I'm not sure we really have analyzed or know enough here, because presumably a lot of these facilities are paid on a cost basis now and yet they're closing and they're closing because you see length of stay is shrinking. This has to do more with how pharmacological interventions have changed the nature of psychiatric treatment.

I'm wondering as we go forward, we're going to be asking does this new system meet the needs. And if the test is more institutions are closing, that might not be a very good test because that's been happening when there aren't

economic incentives to do that and somehow we have to be able to isolate what's going on in this area of diagnosis and treatment in sort of the steady-state to see what the change is.

I'm wondering what are we going to do? Look at other groups of patients and see what's happening.

DR. KAPLAN: I have to be honest and say I haven't given much thought to the monitoring or early warning signs which we'd try to develop for new PPS's and that seems to be what I think you're talking about, that we can't just use entry and exit for at least this new PPS once it's implemented.

But I think that there have been problems with the existing payment system from what I hear. Even though it is cost-based, it is cost-based up to a limit and based on historical costs and not the costs that they currently are necessarily incurring.

So I think I have to get back to you on what our plan would be for monitoring how well the PPS is doing.

MS. BURKE: Just following up on that question, do I also recall you suggesting that Medicare, in most cases, is not the primary. And so the influence of other payers here may be much more dramatic than might be in other

circumstances. So that tracking of why hospitals are doing what they're doing and what's going on with the non-Medicare payments is going to be, I assume, as critical to track unlike in other institutions where we are the big gorilla.

DR. REISCHAUER: Maybe what we want to do is follow the fraction of Medicare patients that receive treatment of this kind and compare it to some other groups.

DR. NELSON: Sally, I inferred -- maybe inaccurately so -- that one of the distinguished characteristics of the population would be that those in the state free-standing hospitals were more likely to be Medicaid dual eligible and that those who are in either hospital-based or freestanding non-government are more likely to be covered by supplemental insurance? Is this inaccurate?

DR. KAPLAN: I have to tell you I don't know. I can tell you what we know about the people in the state hospitals is they're more likely to be committed involuntarily but I don't have the numbers on whether they're duals or not.

DR. NELSON: One could infer that if they're more schizophrenics that they have spent down and have -- so I guess what I'm saying it that one of the things we have to

consider is the impact on the states if we guess wrong, in terms of the prospective pricing. Not only the for-profit freestandings going out of business but also the impact on the state Medicaid agencies and their payment capability.

DR. NEWHOUSE: That last exchange made me wonder, is there are difference in per diem costs for people who are committed, versus people that are not?

DR. KAPLAN: No, but there is a difference in the government-owned hospital patients' costs versus the non-government facilities.

DR. NEWHOUSE: No, I understand that. I'm asking was it looked whether there's a difference within the privates for people that are committed versus people that are not.

DR. KAPLAN: We didn't look at that when we looked, and I didn't see anything about that in the research that CMS talked about in this report, or that I had access to independently.

DR. STOWERS: I don't know how nationwide this was but I know several states, five or six years ago, the governors went in and closed all chronic care psychiatric hospitals and maybe would leave one or two in the state that would handle the acute situation with the idea that it was

"much more humane" to have them be treated in community clinics or other type care settings.

What I know happened in several of our surrounding states, that second step never occurred. So all of the large facilities closed, usually state hospitals, and then the other did not come behind that.

So I'm just wondering what impact and how widespread that was, and that sort of thing on this, if that played into this at all. I know in our state it played a tremendous change and where the Medicare and non-Medicare psychiatric, the number of episodes, how that came to be more in private hospitals. The geri-psych thing kind of bloomed. Maybe that whole phenomenon there should be worked into this somehow.

MS. BURKE: Following up on Ray's point, do we in fact -- I assume we do -- know what the geographic distribution looks like, in terms of the location by type of facility?

DR. KAPLAN: I don't have it with me. We certainly can have that.

MS. BURKE: I think that may help us also pursue Ray's thought, but it also may answer the question of the proportion of essentially free-standing to hospital-based

may help us understand some of the issues in the rural areas as well because you're much more likely to have a hospital-based community hospital with a locked unit rather than a freestanding perhaps. But knowing what the distribution looked like I think would be important to us. It also may help us understand the effect on access issues.

DR. KAPLAN: Okay.

DR. STOWERS: This goes with what Mary said a while ago where you have two facilities left in the state where "someone has to be committed for evaluation" or that sort of thing, none left where there's long-term commitment. Often that's a 200-plus mile drive, usually by the county sheriff's office or whenever to transport these people because none of the private hospitals anymore are doing that kind of detention or evaluation. So it may be the very geographic.

MR. FEEZOR: That's precisely what it is, Ray, in either end of the Carolinas, far eastern or far western.

DR. STOWERS: So it's not uniform at all, I guess.

MS. BURKE: I worked in a psych unit in a community hospital for all the years I was in college and it was in a relatively small town. That was the access. The other access was in Sonoma, the state hospital there.

So I suspect you're going to see that in the communities differently.

MR. HACKBARTH: Thank you, Sally.

Next on the agenda is proposals for expanding the transfer policy for inpatient hospital services.

MR. LISK: Good morning. Today I'm going to discuss Medicare's expanded transfer payment policy for inpatient services. We plan to provide an overview of the current policy and provide some information on the effects of the current expanded transfer policy on Medicare payments to provides based on some previous analysis the Commission conducted back in March of 2000 when the Commission made a recommendation in its report basically stating that the incentives created by Medicare's expanded transfer policy are consistent with the goals of paying efficient provider's costs.

We're going to provide information on the effects of the payments, as I said, and discuss the rationale for the expanded transfer policy, reviewing some of the policy questions that you will need to consider at this time. And also discuss the next steps for what we're going to provide you in December.

From the beginning of the inpatient prospective

payment system, Medicare has had a transfer policy that recognizes that hospitals may not furnish the full course of care implied by the full DRG payment when the patient is discharged to another provider. The transfer policy initially applied to hospital-to-hospital transfers and this is a policy that started from day one of the inpatient prospective payment system. The transferring hospital is paid a graduated per diem payment for the case and the receiving hospital is paid the full DRG for the case.

It's important to remember, though, that when the PPS was first implemented, the use of post-acute care providers was very limited and there was a notion that really post-acute care was a different type of treatment than what is provided in the inpatient setting.

The PPS though provided hospitals with a strong incentive to shorten length of stay. And growth in the availability of and capabilities of post-acute care providers allowed hospitals to shift some of the once provided during the acute care hospital stay to post-acute care settings.

We saw at this point in time, in the mid-90s, when this issue was being discussed, length of stay for instance dropped 22 percent. Inpatient length of stay dropped 22

percent between 1990 and '95. There was substantial growth in this time period in use and spending on post-acute care providers and hospital inpatient margins were rising to record levels. In fact also more than 25 percent, or about 25 percent of discharges, were going to post-acute care providers after an inpatient stay.

Analysis also showed that length of stay declines were greatest in DRGs where post-acute care use was most prevalent, and that hospitals operating these units discharge patients sooner and on average their patients used post-acute care facilities more frequently.

So Congress was concerned that Medicare may, in some cases, be overpaying hospitals for patients who are transferred to post-acute care settings for very short hospital stays. In the Balanced Budget Act of 1997 they expanded the transfer policy to 10 DRGs for discharges to post-acute care settings and allowed the secretary to expanded the policy further starting two years later. But as part of agreements in the BBRA, the secretary agreed to delay any further consideration for two more years, which is fiscal year 2003 and I'll discuss that a little bit later.

Transfers are paid a per diem up to the full DRG. The per diem divides a full DRG payment by the geometric

mean length of stay for the DRG and cases received twice the per diem for the first day of the stay.

So for example, a hospital with a DRG payment of $5,000 and that for that DRG let's say the geometric mean length of stay is five days, the per diem payment rate is $1,000. They receive $2,000 for the first day and $1,000 for each additional day up to the full DRG payment of $5,000. So they reach the full DRG payment one day before the geometric mean length of stay at four days.

Congress also, though, allowed a modified payment for cases that have very high costs in their first day of care, for some types of surgical cases, for instance. In this case hospitals receive half of DRG payment plus one per diem for the first day and half the per diem for subsequent days. Again, as an example, if we assume the same $5,000 case and five day length of stay, this would mean for the first day the hospital would get $2,500 plus $1,000 or $3,500 for the first day and $500 for all subsequent days.

Expensive cases though, very expensive cases though, can also still qualify for outlier cases. And that's actually true for the hospital-to-hospital transfers, as well.

Now the transfer policy applies to PPS-exempt

hospitals and these include SNFs. PPS-exempt hospitals are long-term care hospitals, psych hospitals, rehabilitation hospitals, cancer and children's hospitals, discharges to home with a written plan for home health care that starts within three days of discharge. So those are new home health users rather than people who had been using home health care.

The policy, though does not apply to discharges to swing beds. Now swing beds were originally included in the proposed rule for implementing the expanded transfer policy, but the secretary withdrew this due to industry concerns. Part of the concern was that the conference agreement didn't specifically mention swing beds as one of the comments that was cited in the proposed rule. There was also concern about the potential impact on small rural providers that have swing beds, so they were not included in the initial expansion. But HCFA, at that time, left the door open to including swing bed providers' discharges to swing beds in the future.

In selecting the 10 DRGs for the initial expansion, the secretary chose DRGs with a large number of discharges to post-acute care and a high rate of post-acute care use, and these are the DRGs listed. Only one DRG, 264,

doesn't fit this, but that's because that's a DRG pair where the first DRG, 263, has a complication comorbidity and 264 doesn't. They included both because of the incentive that hospitals might, in order to receive full payment, would otherwise code DRG 264.

I want to now discuss some of the observations about the cases affected by the current policy based on analysis we conducted on a partial year of 1999 data for our March 2000 report. The current 10 DRGs included in the expanded transfer cases include about 9 percent of all cases. And almost two-thirds of these cases were discharged to post-acute care providers or psych hospitals. But less than one-third of the transfers had payments reduced. Overall 1.7 percent of cases had payments reduced if you consider all cases.

The expanded transfer policy, we estimated reduced payments in aggregate to hospitals by about .7 percent for the initial 10 DRGs. Most of these savings were attributable just to DRG 483, which is for tracheostomies. But in terms of the volume of cases with payments reduced, they fell mostly in the hip and femur procedures, DRGs 209 and 210.

Finally it's important to point out that HCFA's

analysis of the initial 10 DRGs show that per diem payments would, on average more than cover the cost of care for the affected transfer cases. The analysis, conducted after the policy was in place, conducted by Health Economics Research, also found that transfer payments more than covered the cost of care for short stay cases affected by the policy. This was also true looking across hospital groups and stuff like that.

Now I want to discuss the policy rationales. There are two strong rationales to support the expanded transfer policy. The first is basically providing a financial neutrality in the payment system, and the second is payment equity across providers. The per case payment system provides a strong financial incentive for hospitals to shorten inpatient stays and, as we discuss in the paper, hospitals can shorten inpatient stays in one of three ways.

They can adopt technologies that enable the patients to leave the hospital sooner and with the same medical outcome. They can shift a portion of care to another setting so the hospital is not responsible for the full course of treatment. Or they can potentially stint on care, potentially discharging the patient quicker and sicker.

Per diem payments provide a more financially neutral payment system. They weaken the strong incentives of a per diem payment to discharge patients as quickly as possible to post-acute settings by bringing payments closer to the incremental cost of care.

This policy is consistent with financial neutrality by matching payments more closely to the incremental cost of each day of care. The transfer policy should make providers indifferent between keeping a patient for an additional day or discharging the patient to an other clinically appropriate setting.

The expanded transfer policy, though, also helps to improve payment equity in two ways. First, it accounts for differences across providers in the availability in use of post-acute care across short-stay cases. In general, it provides a payment reflecting the care provided during the acute inpatient stay, recognizing that use of post-acute care can begin at different points in similar patient stays. This can be due to hospitals that have their own post-acute care units may be able to move their patients sooner than if they had to be moved to another facility, for instance.

In addition, the timing of discharge for post-acute care may be affected by the availability of a post-

acute care bed as well. So in some cases, the hospital may have to keep the patient longer because a post-acute care bed is not available.

Second, in setting DRG weights, transfer cases are counted as partial cases. But when we're not counting them as transfer cases, they're counted as a full case. In this then, for transfer cases, for cases that go on to post-acute care, brings down the DRG weight for those sets of cases. So DRGs with a high post-acute care use, the DRG weight is compressed. So for longer stay cases the weight may be lower than it otherwise would be it.

So I have an example and this DRG, 483, is the DRG with one of the highest rates in the PPS payment system. It's more than 10 times the average for all cases and it has a very long length of stay. The geometric mean length of stay is about 35 days.

So before the expanded transfer policy was put in place, and this is just example. This is not a teaching hospital, a hospital where we're not accounting for differences in wage index, all those things would affect these numbers. But basically before the transfer policy was put in place, a case that stayed 10 days would be paid about $66,000 and a case that stayed 31 days or more would also be

paid $66,000.

After the transfer policy was implemented, the payment would be, for a 10-day, about $23,000. $45,000, $46,000 for a 21-day case. And for a longer stay case, a little more than $72,000. Part of the difference here is why the longer stay case is paid more is reflecting the DRG weight change that is affected here, too.

So this illustrates all the different points that were raised in the payment system, in terms of when you're receiving $66,000 you still have a strong incentive to discharge that patient quicker, potentially to post-acute care settings.

One of the criticisms leveled against the transfer policy is that in a system based on averages, the expansion of the post-acute care transfer policy negatively influences and penalizes hospitals for efficient care. But when care shifted to another setting, where Medicare might still pay for the care, there will be little if any efficiency gained system-wide.

By aligning payments more closely to the marginal cost of care furnished at the end of an acute care stay, the expanded policy encourages use of the most appropriate setting clinically rather than encouraging use of post-acute

care regardless of whether it is more appropriate clinically.

In addition, critics have noted that the transfer policy gives the system a per diem focus that means hospitals are paid less for shorter-than-average stays but not paid more for cases that are longer than average except for outliers. The focus group on hospital discharge planners we discussed yesterday criticized the expanded transfer policy in this way.

They saw the reduced payment as a loss to hospitals since they did not receive the full DRG reimbursement and that's not averaged off against the longer stay cases.

But they also did not look at how the cost of care in terms of what Medicare was paying for these cases compared to what the payment was and that, in fact, in general we're paying more than the cost of care of these cases still. This principle of averaging still applies to the other cases that are not the transfer cases in the payment system.

In the proposed rule for hospital prospective payments in fiscal year 2003, CMS considered two different proposals would expand the policy to all DRGs and the other

would expand the policy only to some additional DRGs that have a high rate of post-acute care use. CMS received a large number of comments on this and they decided not to go forward with the policy at this point in time.

Interestingly, they proposed the policy in the proposed rule, but they did not have any impact analysis of the policy. So they discussed it but didn't have any impact analysis. Keep that in mind. Generally, when they propose something they believe they're going to go forward with, they have the impact analysis for the proposed rule, as well.

They decided one of the reasons they did not go forward though was the limited time to analyze and respond to all the comments they received on the policy. They do, though, plan to conduct some additional research for fiscal year 2004. So this is a policy that is in play for the coming year, still in play for the coming year.

Under a partial expansion CMS considered adding 13 additional DRGs to the list of the current 10. The 13 include three sets of paired DRGS where you have a complication and comorbidity in one and not in the other.

Based on data from 1996, we estimate if the short stay transfer policy were expanded to include these 13 DRGS,

PPS payments would be reduced by about .4 of a percent. If the policy were expanded to all DRG, payments would be reduced by about 1.2 percent for expanding to all DRGs. That's 1.2 percent and we estimate the other for the initial 10 is .7 which has already taken place.

We plan to update these estimates using fiscal year 2001 claims data for the December meeting.

Now also based on this '96 data, if the policy were expanded to all DRGS, less than 6 percent of cases would have payments reduced due to the expanded transfer policy, and that's considering all cases, including the current 10 DRGs.

Now none of these preliminary estimates I provide have adjusted for the modified transfer payment in terms of the higher transfer payment for some DRGs.

Finally, in terms of the policy questions you need to consider, is should the transfer policy for discharge into post-acute care be extended to additional DRGs, all or some? The basic rationale for the expanded transfer policy really applies to all DRGs.

The other issue that we would want you to consider is should discharges to hospital swing beds be included? In December we plan to provide you some impact analysis of

expanded transfer policy to all DRGs, as well as a set of 13 DRGs that the secretary considered in the proposed rule.

We will also provide some information on the impact of expanding the policy to include discharges to swing beds.

I would be happy to answer any questions you'd have at this time, and look forward to hearing your discussion.

MR. HACKBARTH: Crag, one of the central points of discussion in this is whether the transfer policy, the expanded transfer policy is consistent with the underlying principles of the PPS system and whether we're somehow undermining those. I thought the discussion in the paper was helpful in that regard.

In one passage you note that there are three possible situations when a patient leaves the hospital early. One in that the patient is discharged earlier because of some real improvement in care. The outcome is as good or better than before but because the means of care is better they're out of the hospital more quickly. Clearly that's the sort of behavior that ought to be rewarded. That would be quite consistent with the underlying notion of PPS.

A second case is that the patient is pushed out of

the hospital quicker but also sicker. And early on in the system certainly that was a big bone of contention and arguably that's not what we were trying to accomplish with PPS.

Then the third case, of course, is that the transfer where they leave the hospital but they go to another location where Medicare is also paying for care.

Personally I don't think it is inconsistent with the original notion of PPS to say that where we're paying again in another location that there ought to be some reduction in the DRG payment. I think that's quite consistent with the original ideas behind PPS.

I am a little bit concerned, though that we may money the discussion by our reference to financial neutrality which is, at one level, and idea that I've embraced in other settings, that we ought not, through our payment policy be dictating the location of care. That ought to be, so far as possible, a clinical determination about where the patient can be best cared for.

But if you follow financial neutrality to its logical conclusion that we never want to influence the decisions, that in a way seems inconsistent with PPS. The whole idea is that we want to influence how care is

delivered. We don't want financial neutrality, we want incentives. So the repeated use of the financial neutrality label, I'm worried is maybe a little too broad, the concept. We don't always want pure financial neutrality

So that is one aspect of the presentation that troubles me just a bit and I think may contribute to the confusion on this issue about whether this is consistent with the other underlying goals of PPS.

DR. NEWHOUSE: I have a sense of deja vu with this. I think expanding the transfer policy is a good idea. It's obvious that PPS encourages reduction in the length of stay. The question is whether it overly encourages reduction in length of stay. We can focus on Glenn's incentives and one way to say that is if the hospital reduces the length of stay it incurs no cost and pockets the entire DRG payment for the marginal day. And under this system -- I don't have any problem with the more neutral language but if we can find some other language that just describes the change in the incentives.

But for that reason I actually think it's a good idea, but I am worried that we are moving into a system that is still not going to be viable in the long run. I am still persuaded that in long run we'll come eventually to bundling

the post-acute stay in some fashion with the acute stay.

What I'm concerned about, 18 percent, as I recall, of the cases that use post-acute care use multiple post-acute providers. So while this kind of fixes the transfer policy at the level of the hospital, there's an analogous problem for the first post-acute provider and it's not clear to me what's going on, what we're doing. There's some provision that tries to cover that but it strikes me that we keep building and building and it's not likely to work very well.

A second issue Craig really alluded to is that this still remains the minority of patients within each DRG, even if we covered all DRGs. And the incentive argument really applies to all patients, not just to the people that people who happen to be less than the geometric mean, which always struck me as a very artificial division of patients.

MS. DePARLE: On the swing bed policy, I was very persuaded that including that in the transfer policy, including swing beds, would cause problems for rural hospitals. It was partly based on going to some of those hospitals that had swing beds and seeing how our policy might affected their ability to maintain their beds.

At that time the HCFA staff disagreed with me and

we ended up with what you describe, Craig, with the rules saying we're not going forward but we want to think about it.

So when you do your additional analysis, I would appreciate, if there's any ability to look at it and look at rural hospitals in particular and sole community hospitals and whether it would have a differential impact on them. Because at one point I was persuaded that it would.

MR. LISK: Yes, that's what we're attempting to do with that part of the analysis.

DR. WOLTER: Just a few observations because I struggle with this quite frankly. I think that, first of all, as has been mentioned, using the national average length of stay, the mean geometric length of stay, creates an artificial discrimination that may not make sense in this policy.

Also, extending this to all DRGs rather than focusing on -- there's three obvious DRGs where there's issues, tracheostomy and two orthopedic DRGs. And is there a link between those orthopedic DRGs and the fact that SNFs are advantaged if they do rehab and disadvantaged if they don't. And could that possibly be a reason why those DRGs show up on this list? Perhaps if we dealt with simply those

three DRGs, we could deal with something that seems to stick out as a problem but doesn't create the administrative complexity of trying to apply this to all DRGs, which just doesn't make any sense when you look at why the system was put together the way it was. I would strongly argue for that.

I am also very concerned that the landscape is change. Since this was initially discussed SNFs have gone to PPS themselves. As we'll see in the next report, there is a large number of hospitals exiting the SNF business, a very large number, and I think the argument that somehow gaming the system continues to go on is weakened by the exit of those hospitals from the SNF business.

Also the argument that inpatient margins are high and that's one of the reasons to do this I find a little difficult because if you include outpatient hospital margins with inpatient we all know that the mix creates different overall bottom line than when you just look at inpatient. And as we saw last month when you remove things like DSH and IME, the average overall margins drop even further.

So I think that this is a very complex issue. I find the logic personally somewhat tortuous to try to extend

this to all DRGs.

MR. HACKBARTH: Nick, I just want to be clear on one point. From my own perspective, this isn't necessarily about gaming. I don't think it's about intent. It's about result. I think that it's perfectly reasonable for our payment policy to distinguish between a case where the patient is discharged early and goes home with no further expense to the Medicare program in the case when they're discharged early but do go to another site of care that incurs additional expense to the Medicare program.

It's not about whether this was an effort to game the system. It's just a fact.

DR. WOLTER: I guess I'm questioning whether that, in fact, exists anymore when you look at the number of people existing the SNF business.

MR. HACKBARTH: It's not just about hospital-based SNFs.

DR. NEWHOUSE: Another way to put your point maybe is should we use the episode as the basis of payment rather than the stay at each entity?

MS. DePARLE: To be fair, Nick's correct that when all this was being discussed and the BBA was passed, that a lot of the rationale and a lot of the explanation for it was

couched in anecdotes and I think there were some incidents of gaming. But I take his point that a lot has changed since then.

DR. WOLTER: I guess I would say that -- maybe gaming is an unfair way to say it. But the point was made yesterday, in another context, that the way hospitals look at their entire book of business involves cost shifting and looking at where they lose and where they game. And to the extent that there were rehab charges that allowed SNF payments for patients that were more complicated that advantaged you, whether it's good intent or bad intent I'm not really trying to judge that. It just happens.

I'm just trying to put this decision in the context of a bigger picture because most of the argument is based on the specific inpatient margins, et cetera.

I would agree with Joe. We heard from Don Berwick that at some point we need to expand how we look at payment in terms of time and space. That's another problem I find with this. It's another way to look at very specific, almost micromanagement, of the inpatient DRG system as opposed to the fact that these patients do flow through multiple settings in many cases, as has just been pointed out, more than just SNF and hospital.

DR. REISCHAUER: With respect to whether this should be expanded and how far, I'm with Nick. I'd move very cautiously.

One reason is I'd like to see more evidence really on what the impact of the change that we've made so far and you've provided some about length of stay. It's probably maybe too early, but do we know anything about the fraction for each of these DRGs of folks who have transfers to or follow-on post-acute participation, number one. And number two, when we're asking about so what does this mean for the Medicare system as a whole, would there be any way to take these 10 and look at 1997 and look afterwards and see the totality of Medicare spending during the ensuing year or the year starting a month before for a sample of individuals.

The question is what is appropriate?

DR. NEWHOUSE: But how are you going to be able to answer that from knowing the number of people and the amount of spending? I don't see how you get to which is better.

DR. REISCHAUER: I guess you'd have to look at the kind of spending that resulted from -- whether it was up or down and then what it was. Okay, forget about that.

[Laughter.]

MR. SMITH: I share Bob's sense that we ought to

go very slowly here. Glenn, you talked about additional cost to the system. I think we need to be careful with that notion. It's not as if post-acute care is only when sufficient care wasn't provided in the acute care facility. It is part of a continuum of care.

I agree with Joe's often noted idea that we've got to think about the episode differently. I don't think we fix it this way. And I'd be very cautious about a system that has the effect of -- it may penalize game players, but it necessarily penalizes folks who are more efficient.

There is some risk there but I think on balance this is something we ought to -- I'd rather spend more energy trying to figure out how to redefine the episode that we use the PPS for than on figuring out how to expand the transfer payment to more DRGs.

MR. DeBUSK: David covered the question that I had and that was what does this do to the efficient provider concept? It seems like we'd be backing up. This certainly would not be rewarding an acute care facility for taking better care of a patient and getting him out in a shorter period of time.

MR. HACKBARTH: In the case of the hospital that improves the treatment and discharges the patient earlier to

home, I think that they ought to get a greater reward than the hospital that shortens the length of stay and discharges them to another site where we pay an additional sum. And if you treat them equally then I think you're being unfair to the one that has truly made the improvement in efficiency.

MS. BURKE: But you don't know that. You don't know that that's why they've gone to one setting versus another. There are a whole series of issues that could impact why one was discharged to home and why one was discharged to a facility, which may in fact involve the home, the home situation, the nuclear family, the support system, the availability of home can. There are reasons that are unrelated to whether the hospital did the right thing as to where they're discharged.

MR. HACKBARTH: Again, it's not about their motive. What we know for sure is the impact on Medicare expenditure. That's an objective fact. We're paying more in the case when they're discharged to another provider than if they're discharged to home.

MS. BURKE: That's not clear.

MR. SMITH: But it's more as compared to what, Glenn, is the difficulty here. Someone who's discharged to a rehab facility, we would have paid that whenever that

patient was discharged. If the hospital shortened the length of stay, that subsequent cost would still be incurred by the Medicare system as a whole and the same thing would be true if they were discharged to home.

So the question of -- the language of additional cost here seems, to me, to confuse this discussion. It's not additional if it would have occurred anyway. The question is when does it commence? Expanding the transfer policy removes resources from hospitals that discharge in a pattern where it commences earlier. And that is a bit of a guard against gaming. But to suggest somehow that folks aren't going to go to a rehab facility if they get out a day earlier, a day earlier than the geometric mean, that's just not true.

DR. REISCHAUER: So the question is is the length of stay in the hospital related to the length of stay in the rehab facility? And you're making an assumption that there's zero relationship.

MR. SMITH: I agree, which is again while I think Joe is correct in urging us to think about the episode differently.

DR. WOLTER: I just say again, I think what we're doing is we're picking a subset of patients within a DRG and

we're looking at only them. It's my understanding that many patients in that DRG who go to a SNF may, in fact, be at the geometric mean length of stay or even longer and also are sent to SNFs.

Again, I would emphasize, the bigger picture here requires us to look at what's happening in SNF care. And what appears to be happening in SNF care, from the presentations we're receiving at this meeting, is that there is reimbursement for rehab services that favors those types of patients and may create certain incentives. And there are other complex medical patients who have difficulty accessing SNF care. I think that's a bigger issue.

MR. HACKBARTH: Could I just go back to your first point for a second, Nick? Let me make sure I understand this correctly.

It they're at the geometric mean stay or longer and then discharged to a SNF, they're unaffected by the transfer policy. They get the regular DRG payment.

DR. NEWHOUSE: Except, as Craig points out, the regular DRG payment may change, the relative weight may change if the transfer policy kicks in, as in this $66,000 to $72,000 example.

DR. WOLTER: I think to be more specific, my point

was let's say they go beyond the geometric mean length of stay. The hospital may pick up additional cost for the same DRG in those cases before the patient goes to the SNF. We haven't looked at that side of the equation.

Also, the weighting of the DRG problem could be solved by eliminating the transfer policy altogether.

DR. MILLER: Let me clarify that one point. In the instance of this transfer policy, the weight will go up for the DRGS where these cases are occurring; is that right?

MR. LISK: For the DRGs with a substantial post-acute care use, yes. With early discharge, yes.

DR. MILLER: I just wanted to be clear on that.

MR. LISK: Let me just make a point here. Actually, I can't resist one first point, and that is that when you have what might actually be called a true change in productivity, like let's say a non-invasive surgical technique comes into play, generally you're going to expect that change in production mode to transcend all hospitals. And so the result then is going to be that the average length of stay is going to go down. So that phenomenon is not really affected much by the transfer policy because its universal or will become universal.

This applies to the situation where some hospitals

are able to transfer to post-acute and others are not. That was one of the things that we heard from our discharge planners when they were in. We asked them why is length of stay longer in rural hospitals in some of these DRGs? Their answer was because we don't have appropriate SNF in our area. They may have a SNF but they can't handle the rehab, or they may not have anything at all.

So this is intended to differentiate the situations where some do and some do not have access to post-acute care.

But the main point I wanted to bring up was just a reminder that at the next meeting we're going to swing into discussion of our updates and I just wanted to emphasize that this policy is really not about whether margins are too high or too low. That's the role of the updates. We look at the adequacy of payments and decide what adjustment is necessary.

We would be doing that if you recommended expanding the transfer policy and we would be doing it if you do not recommended expanding the transfer policy. Although, obviously our estimate of base costs would be different depending on whether we do or do not have this.

But the main point is that's the place to consider

whether payments are adequate. The transfer policy really is not about whether payments are adequate. It's about an appropriate distribution of payments among different facilities.

DR. ROWE: Yes, but I think Nick was responding to the fact that in the presentation there was, I thought, reference to the fact that in light of the fact that inpatient margins were high, blah, blah, blah.

MR. LISK: That was part of the rationale, that was the historical context of -- I mean, margins were, at that point in time, when Congress was considering this, at the highest they'd ever been and going up substantially.

MR. ASHBY: And perhaps more importantly they had been zooming upwards and it was the decline in the length of stay that was resulting in the increase in margins and everyone was taking note of that at the time.

But that's kind of history. It's really not the reason why we think that this -- it doesn't have anything to do with the reasons for doing this.

MR. HACKBARTH: Others?

DR. STOWERS: Do we have any idea on this expanding, it's all other codes? What's to be saved?

MR. LISK: As I said earlier, the estimate is

about 1.2 percent. So I think if Medicare spending is about $80 billion, that's about $1 billion or so, somewhere around that.

DR. STOWERS: I just think we have to be real careful for the administrative burden to these hospitals and everything, just mentioning and getting back to that.

MR. LISK: Actually, that's a point that had been raised before and is frequently raised. Actually, administrative burden of applying to all cases actually is easier because then there's consistency in how the cases are treated. And having some cases treated this way and some cases not is more problematic administratively. If you had a consistent policy across all cases, then you know how those cases are treated.

MR. HACKBARTH: Anyone else?

DR. WOLTER: I'll just say it one more time, at least I think I saw the data that the large dollar volume involved here applies to one DRG and the large majority of cases applies to two others. And I'm just really struggling with why we're applying this to all DRGs rather than looking at the relationship between those particular issues and then also some of the financial incentives on the SNF side, which would seem to me to be an area that we could mine quite

successfully.

MR. HACKBARTH: Thank you.

Next up is a report on access and utilization of SNFs.

DR. SEAGRAVE: Good morning. As you know, MedPAC uses a wide range of measures in evaluating the adequacy of Medicare payments to providers. These measures include, of course, estimates of Medicare payments relative to providers' estimated costs in the form of margins and various market factors that provide important clues as to whether payments to providers are adequate or not.

We will not be presenting margin information at this meeting, but we will be presenting some preliminary information on some of these market factors measures. This discussion will prepare the Commission for more detailed SNF payment adequacy discussions at subsequent meetings.

First, I want to remind the Commission of the role that skilled nursing facilities play in the Medicare program. In 2000, SNFs provided short-term skilled nursing and rehabilitation services to about 1.4 million beneficiaries at a cost of roughly $10 billion a year. Medicare's average SNF payments per day were about $236, and Medicare's share of nursing home revenues was about 10

percent.

Today CBO projects total payments in 2002 at about $14 billion per year or 6 percent of total Medicare spending and projects that this spending will grow an average of 9 percent per year between 2002 and 2012.

The total number of SNF providers currently participating in Medicare is about 14,800. Ninety percent of these are located in a nursing facility and we call these freestanding, and the rest are hospital-based. About two-thirds of all SNFs are for-profit.

The SNF market factors we will be reviewing today include entry and exit, changes in volume of services, beneficiaries' ability to appropriately access SNF services, and SNFs access to capital.

The total number of SNFs participating in Medicare has declined by about 1 percent between 1998 and 2002. While SNF participation declined in the first three years of this period however, it has remained relatively stable between 2001 and 2002.

The patterns of SNF entry and exit vary substantially depending on a type of SNF you're talking about. Participation of hospital-based SNFs has declined by a total of over 25 percent from 1998 and 2002. But

participation by freestanding SNFs has increased modestly, about 3 percent from 1998 to 2002.

The difference between hospital-based and freestanding SNFs participation may be the result of hospital-based SNFs providing a different product with a higher case-mix of patients, more licensed staff and shorter lengths of stay.

In particular, hospital-based SNFs expanded prior to the SNF PPS, in part as a means for acute care hospitals operating under the strong incentives of the inpatient PPS to discharge patients sooner. However, the fact that many hospital-based SNFs have closed since the implementation of the SNF PPS may indicate that the PPS was not designed to reimburse for the types of services hospital-based SNFs provide.

Further research examining entry and exit using average daily census measures shows similar differences in the behavior of freestanding and hospital-based SNFs. This research also suggests that SNFs did not exit the market entirely in response to changes in PPS payments but that other factors such as bed size, longevity in the market, proportion of Medicare beds, and fracture of Medicare patients requiring rehabilitation therapy, prescription drug

1 therapies, and inhalation therapies may have been at least
2 as support in determining whether SNFs exited the market.
3 For example, this research suggests that
4 freestanding SNFs were more likely to exit if they were new
5 to Medicare, smaller, with a smaller fraction of Medicare
6 beds, and if they had more patients needing expensive
7 prescription drug therapies, or fewer patients requiring the
8 types of rehabilitation therapy, namely physical,
9 occupational and speech therapies for which the SNF PPS
10 appears to reimburse facilities well.
11 The research also suggests that hospital-based
12 SNFs were more likely to exit if they were new to Medicare,
13 for-profit, part of a chain, or if a greater percent of
14 their patients had high drug or inhalation therapy costs.
15 Overall, Medicare beneficiaries use of SNF
16 services does not appear to have declined between 1999 and
17 2000, the most recent period for which we have data.
18 Although the total number of discharges from SNFs declined
19 by less than 1 percent over this period, payments, covered
20 days, and average length of stay all increased by between 4
21 and 10 percent over this period. Payments and average
22 payments per day to SNFs likely increased because of the
23 introduction of both the 4 percent payment add-on to all

rates and the 20 percent payment add-on for 12 complex care payment groups, both of which took effect in April 2000.

Furthermore recent research indicates that many SNFs have been able to reduce their costs per day since the SNF PPS was implemented.

SNF rehabilitation charges per patient per station SNF day in for-profit freestanding SNFs, for example, declined by 46.7 percent from 1997 to 2000. This drop may have been caused, at least in part, by SNFs adapting to the payment incentives under the PPS.

As you heard about yesterday, MedPAC convened a focus group of hospital discharge planners on October 17th to discuss issues of access to post-acute care, including access to SNF services. The 15 discharge planners we talked with told us that rehab patients have reasonably good access to SNF services but that patients with complex needs other than physical, occupational, or speech therapy needs tend to spend at least one day longer in acute care hospitals than they did prior to the SNF PPS. This may indicate that relative payment rates across different types of patients under the SNF PPS do not always track the relative costliness of these patients.

Finally, we analyzed SNFs access to capital and

found that hospital-based SNFs tend to have good access to capital through their parent hospital organizations. Freestanding SNFs, however, may have been impaired access to capital for three reasons.

First bankruptcies have recently occurred in five of the 10 biggest for-profit publicly held companies. Second, the industry has expressed concerns about whether Congress intends to reinstate two temporary payment add-ons that expired on October 1st of this year, and that has introduced uncertainties in their long-term payment rates. Finally, liability lawsuits and higher insurance costs plague this sector as they do in other health care sectors.

However, one key point to recognize is that available information indicates that nursing facilities invested heavily in construction prior to the SNF PPS and there may not be much of a need for capital to finance new construction projects in the near term.

This concludes a brief overview of some of the market factor measures used to evaluate SNF payment adequacy. At this time, I welcome any comments or questions from the Commission.

DR. WAKEFIELD: Just a quick question. When we did the rural report we were looking at data that seemed to

indicate that rural hospitals have longer lengths of stay. And a little bit of our rationale, I think, at that time was about the extent to which that might be adequate post-acute care providers.

When you cut your data is there anything you know, do we have any kind of a breakdown about what kinds of facilities are in rural hospitals, freestanding versus hospital-based, for-profit versus not-for-profit, that might help us get a little bit of a better understanding about that phenomenon that we were seeing of longer average length of stay in those rural hospitals? Anyway of capturing that information, again to try and help understand that.

DR. SEAGRAVE: I don't actually have that data in front of me but we will definitely for the next meeting, we will be looking a lot at rural/urban hospital-based versus freestanding, all of those issues. And I'll make sure that we address the length of stay issue in subsequent meetings.

DR. ROWE: What do we know about the relationship between these bankruptcies? You have five of the 10 biggest for-profit publicly held companies are either restructuring or recently emerged from bankruptcy. What do we know about the relationship between that and the proportion of Medicare revenues of their total revenues? Are nursing homes more

likely to go bankrupt if they're Medicare dependent? Or less likely? Do we know?

DR. SEAGRAVE: We haven't seen any correlation that I know of between their Medicare dependency, since Medicare payments are only about 10 percent of nursing facilities' revenues.

DR. ROWE: I understand, but there is this group with the rehab, as Nick pointed out, that do get paid well, as you said, or adequately. It seemed to me that they would have a greater proportion of Medicare revenues than other long-term care facilities and they might be relatively protected. I just wondered about that.

DR. SEAGRAVE: We can certainly look at that issue with the five that recently emerged from bankruptcy and see.

MS. DePARLE: The ones, I think, that Nick was talking about under the current system were rehab, the payment for patients who need rehab therapy, maybe slightly higher.

Under the old system, before PPS, nursing homes were reimbursed by Medicare on a cost basis and they had incentives to provide lots of additional therapies and there were -- the PPS constrained that. I believe there is some relationship between those two things. A number of those

nursing home chains, I believe, had very high utilization of additional ancillary therapies which were constrained.

DR. NELSON: Is there any information about what the hospital-based SNFs that exited the market redirected the space to? Because the implications are different if they redirected the space to an imaging center or an ambulatory surgical center than if it just closed down beds and the space wasn't used by some other profit center.

DR. SEAGRAVE: Actually it's interesting that you asked that question. We are planning, in about two weeks I believe, to speak with hospital-based SNFs that closed, to interview some. That's one of the particular questions that we plan to ask them.

MS. RAPHAEL: As a follow-up, I think it would be interesting to see what the correlation is between hospitals that closed SNFs that also closed home health care agencies that also might have left the primary care physician practice business and whether or not the decisions were driven by an impetus to kind of focus more on core business or financial strains rather than the nursing home payment system, per se.

The other question that I was just interested in was the drop in charges, the 46 percent drop in charges for

rehab, and your observation that also the amount of time devoted to rehab per patient has dropped. That drop is quite striking.

Do we have any other information about what is happening in terms of the costs and the staffing changes that have occurred in the SNFs during this period?

DR. SEAGRAVE:

We're certainly looking at that issue to try to gather as much evidence as we can about whether in fact -- I think the evidence is pointing to the fact that costs have been dropping over this period. But we're certainly looking at that issue as much as we can. You probably are aware of the GAO report that showed a lot of this. I don't know that we have more information yet than the GAO report and some of the other research that we've presented here, but we're certainly keeping our eyes on that.

DR. MILLER: Do we have a lot of capability to go down to the level that she's looking for in the data? I'm not 100 percent sure that we do.

DR. SEAGRAVE:

Our ability to look directly at facility-level costs, if that's what you mean, we're concerned about the accuracy of the facility-level cost data and our ability to

use that data I think is limited.

MS. RAPHAEL: Because I remembered that there were questions that the SNF sector raised about the GAO report and the data and I'm wondering if we've progressed in regard to the data in this area.

DR. MILLER: We are definitely looking at this issue. I think what I'm just trying to caution against is promising how much we're going to be able to drill down on precisely the question that you're looking for. But we definitely have several things going on right now to try and drill down on that.

MR. HACKBARTH: Any other questions, comments?

Thanks, Susanne.

Last on the agenda is updating home health.

MS CHENG: This morning I'm here to present the beginning of our analysis for this year on updating the home health sector. This is the beginning of our payment adequacy work for this sector. The product that will flow directly from this analysis is the update chapter in the March report.

This morning I'm going to give you little background regarding spending use and current law in the sector and then we're going to discuss four of the factors

that come from our payment adequacy framework. These are intended to give us context and to give us some indication of the relationship of Medicare payments and costs and what changes might have been going on over the past year. The four aspects that we're going to look at, the four factors are product change, beneficiary access to care, agency entry and exit, and agencies' ability to access financial capital.

By way of background, in 2001 Medicare spent about $9 or $10 billion on this sector. It's one of the smaller sectors in the program. It accounted for 4 percent of total Medicare fee-for-service spending in 2001. At it's high point in 1997 Medicare spent $18 billion on this sector and at that time it was about 9 percent of total Medicare fee-for-service spending. Projections for this sector anticipate a pattern of growth that will be driven both by increases in spending per user and in use. Those estimates project that spending will rise to $18 to $20 billion in 2006 and at that time it will be about 7 percent of Medicare fee-for-service spending.

There were 2.2 million beneficiaries using home health in the year 2001. That is a substantial decline from 1997 when over 3 million beneficiaries used home health. There are about 7,000 home health agencies providing the

service certified by Medicare. The current rate for an episode of care is $2,159. Since October 2000, Medicare reimburses home health services on an episode payment system. Agencies are given a fee for a 60-day episode of care. That fee is adjusted for the case mix of the patient based on their clinical severity and their functional limitations. After you apply that case mix adjuster, episode rates range from about $1,000 to about $6000 for 60 days of care.

This year's episode base rate is about 5 percent lower than it was in fiscal 2002. That decrease is the net effect of two provisions of current law that were implemented. The first provision was the legislative update that was marketbasket minus 1.1, so that resulted in a 2.1 increase in the base rate. The second provision that was implemented was a so-called 15 percent cut and that resulted in a 7 percent decrease in the base rate, so the net effect was the 5 percent decrease which we arrive at this year's episode base rate.

The first factor that we're going to look at from the payment adequacy framework is changes in product. This is something that I think we need to keep in mind when we make comparisons in this sector, especially the ones that

was making earlier between 1997 in 2001, is our sense that the produce of home health care in Medicare has changed. The way I've characterized that is from a prevailing mode of maintenance to a prevailing mode of recovery.

The incentives of the payment system since the implementation of the PPS are very different and we think could be driving this change in product. Under the PPS system agencies can maximize their revenue per unit by minimizing the number of visits per episode and making at least five visits per episode to avoid a low utilization payment adjustment, and hitting a therapy threshold to maximize the payment per unit.

We have some that evidence that the change in product is occurring. The first piece of evidence is declining average visits per episode. In 1997, home health agencies delivered an average of 36 visits in a 60-day period. Two years later, that fell to 29 visits, and in the first six months of 2002 that decreased further to 20 visits per episode.

The second piece of evidence that we have that our produce is changing is increasing use of therapy services. In the maintenance mode, the emphasis was on relatively low intensity aide visits, and in the recovery mode the emphasis

is on therapy visits. In 1997, 10 percent of all visits were therapy, and in the 2001 that had risen to 20 percent. In 1997, aide visits were 50 percent of all visits and in 2001 that had fallen to 30 percent of all visits.

However, there's one aspect of the product that hasn't changed despite incentives in the payment system and that's the persistence of very short episodes. When an episode contains four or fewer visits, rather than receiving the full episode payment, agencies are reimbursed by visit type. The highest per-visit payment is lower than the lowest episode physician. So there's a strong incentive to deliver that fifth visit and trigger a full episode payment. Before this incentive existed, 15 percent of all episodes contained four or fewer visits, and after we implemented the PPS, 14 percent of all episodes had four or fewer visits, so virtually no change.

The second factor from the payment adequacy framework that we're going to present is beneficiary access to care. This again is drawing from the panel of discharge planners that MedPAC convened, and generally speaking they offered no evidence of increased difficulties with placing most patients in home health care since the implementation of the PPS.

They did report experiences ranging from a one-day delay to an inability to find services with a few patients in a few subgroups. They told us that patients are more difficult to place in rural areas, especially if therapy is needed. Also, patients requiring wound care, daily care, or expensive medications were among those more difficult to place, as were patients with mental illness or cognitive impairments. Members of the panel, however, did not specify which, if any, of these hard-to-place groups were newly hard to place or more hard to place since the implementation of the PPS.

We also looked at some other new research that's available that looked at the period prior to the PPS. This research found some access problems for the medically complex and for rural beneficiaries and suggests places that we need to continue to monitor closely as look at access under the PPS.

The next factor that we took a look at was agency entry and exit. There are currently about 7,000 parent home health agencies. Now whenever I've talked to the Commission about the number of agencies in the past I've always had a caveat that we're not seeing the complete picture because we haven't had a count of the number of subunits or branches

that might be below the parents level. The good news is that CMS this year is numbering branches and is counting them, so when we talk about this information next year we're going to have a much fuller picture of the number of agencies that are currently serving Medicare beneficiaries.

But concentrating on the numbers that we have and the trend that we have one parent agencies we see at its high point again in 1997, over 10,000 agencies were serving Medicare beneficiaries. The decline between 1997 and 2000 was due in part to merger and acquisition activity as well as agencies actually exiting the program. There have been about the same number, about 7,000 agencies in the program for the past three years.

Before the PPS this indicator might have been sensitive to under-adequacy of payments as we saw a pattern of exit from the program. However, since the PPS this indicator might not be providing us a lot of evidence about the possibility of adequate or over-adequate payments because some barriers to entry might exist after 2000 that did not exist before. The PPS system favors large agencies that can average their profit and loss over a large patient base that are clinically different.

Also there's a new level of computerization that's

required with the implementation of the PPS for reporting patient-level assessment data, so that new level of computerization is higher than it was in the past, and the nature of the PPS might both inhibit the entry of agencies following the PPS.

Also there's a CON limitation which allows states to manage the number of agencies in their state, in 16 state, and that also might be a barrier for new agencies that would seek to enter the program.

To taken together, what do these factors give us as a picture of what's happened in the sector over the past year. We think it's important to keep in mind that the home health product may be continuing to change. From the evidence that we've reviewed, we see no evidence of change in access to care. Entry and exit from the program has remained stable.

The last factor up on the slide is access to capital. This may be more useful in other sectors, but home health agencies do not tend to rely on the bonds. They do not tend to offer shares of public stock, and that doesn't seem to be related to the relationship of Medicare's payment to cost, but seems more determined primarily by the size of home health agencies -- they're relatively small --

and the role that home health would have in any portfolio of health care generally, which would also be small.

When this sector does access financial capital it tends to do so through bank loans or loans against Medicare receivables. That might be expensive financing and it might be risky, but overall access to capital isn't probably a very good indicator for this sector.

In our next presentation what we hope to be able to bring you is more detail on the changes in volume that have been going on in this sector over the past year. We're also very hopeful that we'll have cost reports that will reflect some of the post-PPS experience of this sector. If we can get those to you we'll be able to estimate current payments and costs and project payments and costs for the next year so that we can start thinking about our update recommendation.

At this time staff seeks from you your input and your sense on the factors that we've covered, what other kinds of detail would you like on those factors, if any, and any directions or any slices of the data that you'd like to see as we put together our analysis for the next steps.

MR. HACKBARTH:

Sharon, a quick question about the analysis we do.

The patterns of use in home health vary widely from state to state. The number of visits per episode are just really different as you go across the country. Doesn't that pose a particular challenge in terms of analyzing the financial impact of the system and reaching a conclusion about an appropriate national update?

If you just look at all averages and some states started with 70 visits per episode, they can come down a lot from where they are and change average numbers a lot, whereas states that started at a much lower number may be in a different place. How do we understand what's being concealed by just looking at averages?

MS. CHENG: Part of the good news is since 1997, though we've always had a wide variation from state to state in the number of visits per episode, our variation is actually shrinking, so that seems to be a self-addressing problem in the data. We're going to keep that in mind. Hopefully, to the extent that we can capture those differences we're going to look at regional rates of the use as well as a state rate of use. Also, hopefully by looking at the experience of agencies, profit, not-for-profit, government-owned and non, rural and urban, to the extent that that might have some explanatory power we're going to

be able to get behind some of those national averages a little bit.

DR. NELSON: You talked about the spread. What's the average and the median in the visits per episode?

MS. CHENG: In the first six months of 2002 the average visits per episode were 20 and the median was lower than that. We used to have about, I think, a five-fold variation from the lowest state to the highest state, and that's shrunk. I think it's down to about three. So we do have some high states that pull up that average, but we can keep median and mean numbers for that.

MR. SMITH: Just quick question, Sharon, about the entry and exit data. With the incentives that you mentioned to size, did the entry and exit data reflect a reduction in capacity or consolidation, merger, acquisition as well?

MS. CHENG: That's always a caveat that I've tried to put on those entry and exit numbers. I think entry and exit can tell us a lot about decisions that are made agency to agency. I think that entry and exit isn't real useful in trying to get a sense of the capacity of the system because agencies vary widely in size. We are quite literally talking about mom-and-pop agencies all the way up to the VNA system and some of the larger for-profit chains. So just

counting the number of agencies doesn't tell us a lot about capacity.

We can tell you about changing in use under that, but it's also rather difficult -- I can tell you how many visits an agency delivered last year, but you can see that that might not be a terribly good measure of their capacity for next year.

MR. SMITH: What other capacity measures and indices have been explored or might be useful to explore?

MS. CHENG: We've thought about looking at the availability of nurses, the availability of therapists. That runs into some analytical problems as well. We can try to examine that a little bit.

MR. SMITH: I was wondering if employment itself might be a useful proxy for capacity -- employment in the industry.

DR. REISCHAUER:

This is at industry which can expand with relatively little in the way of investments, so all you can really look at is the number of visits or the utilization really, unless you have some other mechanism which shows unmet need.

MS. RAPHAEL: A couple of observations. I think

it is important to note the drop in the utilization of this benefit which has that very dramatic. From '97 you had 73 beneficiaries per 1,000 and now it's down to about 38 per 1,000, so it has been just, I think, a remarkable drop in those using the benefits that we should be aware of. I don't think we fully know all the reasons for it although we have some hypotheses.

Secondly, I think in terms of the access issues around the medically complex, I think that part of the variable there has to do with survey issue, because surveyors require home health agencies to make sure that their patient are what's called in the lingo, self-directing. It makes it very hard to have a self-directing patient who's cognitively impaired. So citations increase proportionately when you take a risk and you admit a patient, you're more likely to have problems.

I think the access to capital issue, as you pointed out, Sharon, is very different. I think you did a very good job here of laying out what are the trends and issues. But I think we should be mindful of the fact that the 7,000 agencies that we have are primarily small agencies, and access to capital is an issue because you need to capital for systems these days. That's your highest

capital expenditure. Most of these agencies -- or you need it for cash flow because there's been payment changes under PPS. Most of these agencies have a very hard time accessing capital, and their costs are very high to do it. So I think it is a different set of issues but it is an important issue.

Lastly, I think that I'd like to better understand how you're going to get at the change in product, because mostly we talk about the fact that visits per user has gone down. In fact it has. But we believe that the length of time of a visit has gone up. So a visit now might be two hours and initially it might even more than that. And the nature of what we're doing has changed.

I'm just curious as to how you're going to try to get at that part of your analysis.

MS. CHENG: CMS has also instituted a reporting requirement that visits be reported in 15-minute increments. That's fairly new data. What we hope to be able to do is to look at those 15-minute increments and get a sense of how long visits are now. We don't have a real good baseline to compare it to. I can't tell you how long a visit was in 1997. So hopefully we'll be able to get in there, we'll be able to get a baseline and look at the changes. So that

will tell us a little bit about visit length.

Also, at the claims level we're going to try to look at non-visit services, see what kind of supplies they're using in a visit. That might tell us a little bit about what kind of treatments are going on.

Other than that, another option that we're keeping would be another kind of focus group to talk about how care has changed, talk with clinicians, talk with nurses and doctors to get their sense too of what's happening that's different, that's not necessarily going to show up on a claim. Some of this home health is a little bit of a black box. We know that the visit type was nursing but we can't differentiate between caring for a wound, instructing a caregiver, reading vital signs. We don't have that level of data to see some of the qualitative changes from the data. So if we've got that focus group, maybe we can get some clinical input.

MR. HACKBARTH: Carol, what's been your experience? A decline in visits and a change in the character of the visits, the duration of visits?

MS. RAPHAEL: Our experience has not been the norm. Our visits have gone down very minimally, so we are definitely not showing the decline in either number of

visits or in other kind of use of home health aide services. We're seeing a more complex population with more comorbidities, more very late stage four wounds that are very complex. So we have not seen the same drop.

We are seeing longer visits, particularly at the admission level, or readmission if they go back and forth to the hospital.

DR. WAKEFIELD:

Sharon, on the changes in product that you discussed, specifically increasing use of therapy services, it seems to me I recall that, again, when we did the rural report that there are some significant differences in the extent to which therapy services. All things basically held equal about the patient population, no differences in the patient but that what tended to be fielded in rural areas were less intense services. Maybe that was a good thing and patients didn't really need in other settings as much intense therapy, or maybe it was lack of access to physical therapists and techs were being used or whatever.

So one of the questions I guess I've got for you is that when we're looking at more data will we be able to see what's going on in that rural category that at least about a year and-a-half ago was clearly fielding a different

set of services, for whatever reasons, compared to their urban counterparts. Because when we look at this increasing use of therapy service it would be really interesting to see, is that trend also true in rural areas, especially when we know that the baseline isn't -- they're not both starting at the same place generally speaking. So that's just a comment.

Then when you mentioned that CMS will have -- we'll be able to see a little bit more data about both parent and satellite, or whatever you call them, facilities, will you remind me again about how they look at coverage? For example, I think I recall talking to home health folks -- and this would have been a while ago -- that some home health agencies, for example, are licensed to provide care and counties but they don't necessarily provide care. So it looks like on the face of it that care might be available, but there's a very deliberate decision, for whatever reasons, lack of adequate workforce or whatever, to not -- they're licensed to provide there but they don't actually provide services there.

So I was wondering, are they spinning off of where these agencies are licensed to provide care, or are they using some other measure of availability of services?

MS. CHENG: That's been another real bugaboo in the data. We don't know a lot about the service area of a home health agency. Again, that's something that we observe. If they served a beneficiary in that county we presume that was their service area. So being able to count the branches is going to help a little bit because that's going to tell us a little more than we knew when we just saw a parent agency in one area. We'll be able to see that they have branches.

It's not going to tell us a lot more about their service area of the extent to which they serve beneficiaries in other counties where the agency isn't located itself.

MR. DeBUSK: [Off microphone.] For maximum desired payment you've got to get therapy services or you've got to qualify for so many visits. We've identified with access that wound care, diabetic ulcers, this is a major, major issue and there's a real question as to how well that's paid in the episode it falls in.

But in looking at this, and our speaker last meeting talked about preventive medicines, better ways to do things and reduce cost. If we knew, if there was some data that showed how many patients who had diabetic ulcers, wounds, how many of those patients end up in super-expensive

surgical procedures at the acute care setting, I think those numbers would really be astonishing.

But look at the system and the episodes under the OASIS system, there's 50 episodes. It says, episodes of four or fewer visits are subject to the low utilization payment adjustment, the LUPA. If there's ever a place in this whole scheme of things where maybe we could enter prophylactic therapy or preventive medicine and really reduce some major costs, it looks to me like in that area right there would be plenty of room to address wound care and how to better take care of some of our Medicare patients, our senior citizens, with something that's just a terrible, terrible disease today.

There's no doubt, we're not adequately addressing this. There's an opportunity to reduce cost here and improve access. So all the things line up. How do we get into it? I don't know, but certainly the issue has been pointed out.

MS. DePARLE: You noted that the 15 percent reduction that was in the BBA actually went into effect in October and I guess it ends up being more like a 7 percent reduction. Will we have any sense of the impact of that, or I guess just the absolute lower amount of payment by the

time we make our update recommendations?

MS. CHENG: I don't think so. We'll be able to model current law, we'll be able to look at the current level of payments with that reduction in place. And to that extent we'll be able to take it into consideration but I can't imagine that we would be able to observe the effects by December, no.

MS. DePARLE: But the net impact, if I heard you correctly, of that plus the update for this year means that for FY 2003 the average payment is about 5 percent lower? Is that what you said?

MS. CHENG: The base rate goes down 5 percent, and for LUPAs the payment per visit by visit type also go down 5 percent.

MS. DePARLE: Do we had any ability to look at -- I understand that the agency has made some recent changes or clarifications about the homebound definition. Do we had any way of analyzing whether that has any impact or is likely to.

MS. CHENG: I think we can. We can talk about the homebound definition which has been changing and its changing and how that might have affected eligibility.

DR. ROWE: I think most people view this sector as

not very capital intensive and I think that we tend not to focus enough on that. I think that is going to be an important part of this and I'd like to see you provide us with information, Sharon, not just on whether they're having trouble getting capital but the sources and the uses of the capital, particularly with respect to Carol's point about the systems. The information systems may be an underappreciated need here.

While their costs may be high relative to other enterprises that are seeking capital, we're also in an environment in which interest rates have fallen dramatically for a couple of years. So their costs may be lower than they were before, significantly so.

So I think it would be interesting to get some data on what the actual costs of capital are for these organizations as well as their uses.

MR. FEEZOR: [off microphone] Jack, you're assuming that their attractiveness to the capital market would remain the same. In light of the reimbursement, that may not be the case.

DR. ROWE: I'm questioning that, yes. I just think it's an interesting -- rather than just they are -- 10 percent report trouble getting capital or they don't report

trouble. It would be interesting to have a little more detail. We were talking, some of these moms-and-pops go out and get second mortgage on their house as capital, collateralized it on something other than the Medicare accounts receivable. And those interest rates are low compared with what they were before.

MS. RAPHAEL: I think it's a good point because I took a look at percent of revenues we're spending on information technology compared to hospitals and we're spending exactly the same percentage. We benchmarked ourselves. And I think people don't realize that you do have to expend a significant amount of capital in home health care.

MR. HACKBARTH: We've made reference a couple of times to the unique character, if you will, of this very industry with many very small operations, thinly capitalized operations. Another characteristic, as I recall, that we think makes this a little bit different than some other sectors is the relative absence of a really clearly defined product and clinical standards on what constitutes appropriate care. Am I remembering that correctly? Help me out, Carol and other people.

Given that, I guess sort of a nagging concern that

I have is that this industry might be elastic in another way. If you shrink the money available, they are going to shrink with they do. They don't have the means to continue to take losses and there's no clear clinical standard to say way when the shrinkage has gone too far.

How we deal with that problem?

DR. REISCHAUER: It certainly is an issue and to the extent that identifying the efficient provider as one that provides good care with high quality at the best price, this sector is as prone to those questions as every other sector.

What we do have in home health that we might not have in some other sectors is a very well developed set of outcome measures. We've got the OASIS outcome assessments measures in place. We've been measuring those, checking their validity, and hopefully we'll start to be able to talk about outcomes.

So while we've still got that 60-day episode and we've got things going on in there, we should at least be able to say a patient arrived in this condition and left in this condition, and we did something positive in the meantime.

So to the extent that we can look at outcomes,

we'll know a little bit more about what's going on with the efficient provider and producing a health care product that Medicare is interested in buying. That's down the road. I think that's a real rich avenue to explore and I hope we'll be able to do more work like that.

DR. REISCHAUER: Just a note on that, it is but it's from where we are today rather than from what home health looked like two years ago, three years ago.

Jack made the point that I was going to make, and so I'll just add a couple of things to it. One is that I think if we go into this descriptive piece on what the capital requirements are you to talk about the Carol's outfit and the ma-and-pa, you don't want average them.

But there's another dimension to this and that is tax law changes and while there's the cost of capital in terms of bank loans and mortgage rates, or whatever you want, we also changed tax law and probably will change it again to increase the amount of expensing of capital investment that can be done. I'd like, particularly on this information technology issue, how much is required? Is it below the $25,000 threshold or not? Because if it is, then shouldn't be a constraint.

MR. DURENBERGER: Could I better understand the

answer to the question that David Smith raised relative to the provider? In other words, I'm making some assumptions about what's going on in the workforce and health care generally. But particularly if you're talking about smaller operations, people needing access to fringe benefits, one of those benefits being medical coverage and issues like that Why is not the current pressure on the health care workforce a major factor as it relates to the cost, probably a factor that varies from one place to another but such a major factor that it deserves some special analysis.

MR. HACKBARTH: You're not talking now specific to home health but a generic issue with regard to the health care.

MR. DURENBERGER: Because the agency is small, there's few providers. The cost of hiring each person or hiring each person is probably higher than it might be in a larger institutions or something like that. But I don't know. I don't know market to market for what you're competing. I just make the assumption when I see the prices that nurses are being paid going up and up and up and up and up, that home health becomes a substantially less attractive -- unless you happen to be the spouse of someone who lives in a rural and home health is -- everything else is filled

up so home health is an opportunity or something like that.

MR. HACKBARTH: And home health agencies might be particularly susceptible to recruitment issues and vulnerable to increases in wage level.

MR. DURENBERGER: I don't know that's the fact. I'm just asking the question.

MS. RAPHAEL: I don't know, in general, labor costs are a very high percentage of home health care costs overall, I think in the range of 80 percent. And I think that the markets that they have to compete in involves hospitals, nursing homes, et cetera, and they have to be competitive in compensation.

I think the job is a tough job and I think they are very prone to having recruitment issues and competing in that marketplace because going out and making many visits per day takes an intrepid person to do. So they are very very much influencing certain area, shortages are very serious and affect capacity much more than anything else.

But I don't know how you would get at that right now and how it would influence which you would recommend.

MS. CHENG: There are members of our staff who have a great deal more insight and experience. I'd like to be able to refer you over there because I think the issue of

measuring input prices, labor among them, is something that we've looked at and we can talk to you about.

MR. HACKBARTH: One las quick thing, Sharon. I think it was last April GAO came out with a report analyzing trends in home health costs that got a lot of publicity at the time and I've heard a number of people on the Hill make reference to it.

It would be helpful to me if at our next discussion of this if you could just refresh us on what was in that report. The headline, as I recall, was GAO shows that home health agencies have dramatically reduced their costs in response to PPS, even though we didn't at that point have any PPS data but they inferred that from other things. So if you could remind us what was in that, that would be helpful to me.

Any other questions or comments about this? Okay, thank you.

Now we'll have our public comment period.

MR. PYLES: Takes very much. I'm Jim Pyles, representing the American Association for Home Care.

A couple of the points I wanted to mention, I think, have been touched on by Dr. Rowe and by Ms. Raphael and Senator Durenberger. But just let me summarize a couple

of things that I think are very important to keep in mind with respect to home health.

One is this sector has experienced the most radical changes in payments, patients, and providers of any benefit category in the history of the Medicare program, I believe. I don't know of any other program that has seen over a shorter period of time the radical change, 52 percent reduction in payments between 1997 and 1999 but a 40 percent reduction in providers, and about a one-third reduction in patients treated.

We know that distribution was heavily concentrated in the most complex, costly patients. So the patient population has shifted rather radically.

Higher nursing costs, certainly every provider is experiencing those, but as Ms. Raphael says, the personnel costs for home health agencies are much higher than for any other providers. So the higher nursing costs hit home health agencies much harder.

Plus, it is not just the impact is greater but the kinds of nurses you need in home health are nurses with particular expertise to deal with things that nurses in facilities do not have to deal with. Retaining experienced nurses is extraordinarily difficult. You have to pay these

people and provide appropriate incentives for them to stay in the business. It is a tough, tough job.

We also know that the service mix has shifted under PPS away from lower skilled people to higher skilled people, once again placing more pressure on higher cost employees. Medical liability costs have gone up for home health just as they have for every other provider. Health insurance costs have increased by double digit amounts in the last two years and are projected to go up 30 percent next year. The same is true for home health agencies.

The difference with home health agencies is most of their costs are in the personnel and fringe benefit areas, as Senator Durenberger pointed out.

HIPAA compliance, transaction, privacy costs, both of those standards go into effect next year. Home health is struggling hard to try to comply with those new standards.

Understand, too, and remember if you would, you recommended previously that what this industry needed most was stability. That is absolutely essential because with the dramatic decline in reimbursement under the government programs has left a residual impact. Many, many agencies now are still making repayments on extended repayment plans to CMS that were caused by dramatic and abrupt reductions

under the interim payment system.

They could not go into the market and borrow money to pay that off, so they have had to just enter into those repayment plans with CMS. The percentage rate on those repayment plans is 14 percent. Fourteen percent in this market. That's because they cannot go out into the market and find other money to pay that off

Adding insult to injury, two very recent developments. One is the 15 percent cut has just begun to take effect. Of course we know it's about a 7 percent reduction, but that's on top of the 52 percent cuts we previously had. Agencies are scrambling right now to try to accommodate that and they're doing it, some of them we're finding now are doing it by just refusing to treat the more costly patients. They can't do it. They don't have the money to do it or the personnel to do it.

And most recently, as recently as last week, the largest financing organization in the country for home health collapsed. National Century Financial Enterprises, it's been in the headlines of the business sections of the paper, has collapsed. They were in the business of financing receivables. This was the only financing source for many home health agencies.

Just this week CMS has told agencies that were relying on that financing that CMS will cut off all further payments to home health unless they can find an alternate source. There is no alternate source of funding for many of these agencies.

Over the next few weeks you're going to see some major reductions in providers, in home health providers in this country as a result of these events.

One last thing I would mention to you on the number of offices, that 7,000 agents HHA number may be deceptively high because within the last year CMS has issued a policy saying that states can require home health agencies to get a separate provider number in each state in which they do business. For example, in the DC Metropolitan area we have commonly the situation where one agency since maybe 1965 has served patients in DC, Maryland and Virginia. Under this recent policy now, that one agency will have to establish two additional provider numbers, giving the appearance of an increase in the number of providers. But what they're really doing is converting branch offices to freestanding providers.

This is going to skew that number higher. So I suspect you actually have an even greater net reduction in

the number of providers.

One last thing I would mention is that the house passed bill, a Medicare bill, which would have eliminated the 15 percent cut, also included a provision recommending that you look at the budgetary impact of your recommendations when you make them in the future. Should you decide to follow that, I would urge you to also look at the fact that the provision in the House bill for home health relief is self-funded. It takes the cost of eliminating the 15 percent cut out of market basket updates in future years so that the net cost of eliminating the 15 percent cut is zero.

Thanks very much.

MR. MAY: Thank you. I'm Don May with the American Hospital Association and I appreciate the opportunity to comment here today.

We'd like to just make one point on your discussion on the transfer provision. As you might guess, the AHA is strongly opposed to any expansion of the transfer policy, but it's because it's a bad policy.

A prospective payment system is based on a system of averages and with any DRG we can have a low length of stay and be able to cover our costs for that, have a high

length of stay and not cover costs. But at the end of the day, at the end of the year, you hope that the system of averages has worked in your favor.

Expanding the transfer provision and reducing payments to cases that get sent to post-acute care means that we're going to lose on those cases that have a lower length of stay and we lose on the cases that have a higher length of stay.

It's just a policy that doesn't make sense and has a huge impact on hospitals and the care and the funding that's available to provide access to care.

We have done research on this and all the research that we've been able to come up with show that patients -- and I think it's consistent across most research that's been done on this -- patients who receive post-acute care are sicker. They're getting post-acute care for a reason.

Whether that's that they live in a nursing home, they need extended care at home. But regardless of whether they're leaving the hospital early because a hospital is able to do something in a more efficient manner, they're going to be sicker and they need that care. Penalizing a hospital is not the way about addressing the post-acute care issues.

One of the arguments for doing this is that there's a lack of equity in the system. That those hospitals who have access to post-acute care are able to use that service more often and have a lower length of stay than those other hospitals.

The policy to fix that solution is not to cut those hospitals who have access to post-acute care. It's about finding ways of putting post-acute care in those areas where there's not access. There are two very distinct and different policies there and we really need to focus on extending post-acute care in those areas that don't have it and not making cuts to hospitals.

I was really encouraged by a lot of the discussion here and some of the real concerns that several commissioners brought up. I would like to make a quick note in the inpatient proposed rule that came out, CMS actually came up with different numbers than what Craig had as far as the impact. What we're hearing is that it's $1 billion for 13 more DRGs, $.9 billion, and $1.9 billion for expanding it to all DRGs.

We did some research as well once this was proposed, as you might imagine. Our estimates and the estimates of some others we've talked to indicate that it

may be even more. It's very difficult to do the data analysis because we don't have patient identifiers that allow us to do all the exact linking.

But if we did, our estimates would only go up. This is consistent with other researchers.

What this means is remember it's not just a one year hit. $1 billion or $1.9 billion in one year means $10 billion in five years and $20 billion in 10 years. The impact of that is tremendous on America's hospitals. And it's something that, as you move forward, we would strongly recommend that you be cautious in recommending anything on this.

I was real encouraged by some of the other ideas they came out. In looking at some of the three primary DRGs that seem to be problematic, being real cautious and looking at swing beds and the impact on rural hospitals, and looking at the whole bundle and whether there are other ways of looking at this that could address some of the concerns that the Commission has raised, that Congress has raised without just slashing payments in a way that doesn't improve access to post-acute care and doesn't address the fundamental problems that hospitals have today that all providers are having today with workforce shortages.

This is really not the time to be cutting payments when workforce shortages are driving up costs. Liability and professional liability costs are going up. All the trends indicate that the costs of providers are going up. This is an opposite direction if you want to continue to ensure access to both hospital and post-acute care.

Thank you.

MR. LISK: I just wanted to say that in the paper I had indicated -- and I didn't give the CMS numbers because the CMS numbers that were in the proposed rule were wrong. They don't have official revised numbers. We will provide you numbers in terms of our estimate of what the impact is at the December meeting. But the numbers that CMS provided, first of all, that were in the proposed rule, that were just cited, also included the current 10 DRGs but, in fact, the numbers are not actually correct and have been revised downward. But I can't say what those numbers are at this point in time.

MS. THOMPSON: Hi. Thank you for the opportunity to comment. I'm Cathy Thompson with the Visiting Nurse Association of America.

VNAA is just starting now to look at data on how the nursing shortage is affecting visiting nurse agencies in

particular. We don't have really good hard data at this time but we do want to work with MedPAC on getting that data.

We do show that there is about a 15 to 20 percent RN vacancy rate among visiting nurse associations and about a 25 to 30 percent home health aide vacancy rate. We do have data showing that those recruitment costs do eat significantly into the revenue of visiting nurse agencies.

My concern is that when data comes out, if data comes out showing that Medicare revenue exceeds expenditures that there will be a knee jerk reaction to then recommend or for Congress to consider decreases in Medicare reimbursement for home health or to not repeal the 15 percent cut which we know is pending in Congress.

Our data does show that if there are any margins at all, very small, they're completely wiped away by the technology cost to comply with that Medicare regulations, particularly OASIS and HIPAA and PPS. That VNAs budgets, on average, are quite small compared to the rest of the health care industry. And that they do disproportionately wipe out a lot of the revenue that VNAs have.

So in addition to the IT cost, the increased salaries and benefits to recruit nurses, during the

shortage, and home health aides, in addition to losses in Medicare and managed care, we do have data on all of that and would love to share it with MedPAC, just to balance out when Medicare data under PPS becomes available.

We don't know what that's going to show now, but I just wanted to raise those issues. Thank you.

MR. HACKBARTH: Okay, thank you all.

[Whereupon, at 11:55 a.m., the meeting was adjourned.]

1